

MI/PQC Request Form
STRIDES ARCOLAB LIMITED

Case Type (all applicable) <input type="checkbox"/> AE <input type="checkbox"/> MI <input type="checkbox"/> PQC <input type="checkbox"/> Replacement <input type="checkbox"/> Refund Requested by: _____
Report sequence <input type="checkbox"/> initial <input type="checkbox"/> follow up

Reporter Data				
Last Name	First name	Middle initial		
Address:	City:	State:	Zip code:	Country:
Phone number:	Fax number:	Email:	Institution:	Country of occurrence:
Primary Reporter: <input type="checkbox"/> Yes <input type="checkbox"/> No	Healthcare Professional: <input type="checkbox"/> yes <input type="checkbox"/> No	HCP Category:		

Primary contact:	Name of the pharmacy:		
Last Name:	First Name:	Middle Initials:	
Address:	City:	State:	Zip Code:
	Country:		
Phone number:	Fax number:	Email:	

Product Information			
Product Name:	Strength:	Dosage form:	
Package size:	Packages:	Batch/Lot #:	Expiration Date:
Did the reporter contact before: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of previous contact:		
Narrative: Provide the clear description of the sequence of events, and any other relevant details			

Prepared by: _____

Date & Sign: _____

F-03-R0/GPV-013