Arco Lab Pvt Ltd	**TITLE: MI/PQC Reporting Form**

Case Type (all applicable) ☐ AE ☐ MI ☐ PQC ☐ Replacement ☐ Refund
Requested by: ________

Report sequence ☐ Initial ☐ 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: ☐ Yes ☐ No	Healthcare Professional: ☐ Yes ☐ 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: ☐ Yes ☐ No	Date of previous contact:	
Narrative: Provide the clear description of the sequence of events, and any other relevant details		

Filled by (Name): ______________

Reviewed by (Name)_______________