Author Signature

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| ***Name*** | ***Role*** | ***Date*** | ***Signature*** |
| Nuno Lages | Author | 16-Jan-2019 |  |

Approver Signatures

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| ***Name*** | ***Role*** | ***Date*** | ***Signature*** |
| José Pedro Fernandes | IT Dierctor | 16-Jan-2019 |  |

Revision History

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| ***Version*** | ***Date*** | ***Reason for changes*** | ***Description of changes made*** |
| 1.0 | 18-Apr-2018 | Initial document | N/A |
| 2.0 | 26-Apr-2018 | Template corrections | Template corrections regarding document name and page numbering. |
| 3.0 | 08-May-2018 | Corrections and clarifications | Additional information added (trade register extract). |
| 4.0 | 16-Jan-2019 | New field | Identification of the Main Client Contact Person |

THE SOLE FUNCTION OF THE ABOVE TEXT IS TO APPROVE THE VERSION OF THIS CHANGE REQUEST TEMPLATE AND TO MAINTAIN THE REVISION HISTORY. IT IS NOT PART OF THE CHANGE REQUEST TEMPLATE ITSELF. NOTE THAT A SEPARATE HEADER AND FOOTER IS USED ON THIS FIRST PAGE.

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| **REQUEST – To be completed by the representative of the entity** |
| **System Name** | Portuguese Medicines Verification System (PTMVS) |
| **Request Type** |
|[ ]  New Account |
|[ ]  Update Existing Account | Account ID: |  |
| [ ]  | Retire Account | Account ID: |  |
| **Entity information** |
| Entity name: |  |
| Postal address: |  |
| E-mail address: |  |
| Phone number: |  |
| Type of end user: | [ ]  | Pharmacy | [ ]  | Hospital pharmacy |
|  | [ ]  | Other entity authorized to dispense medicines | [ ]  | Wholesale company |
| Fiscal Number: |  |
| License number: 1) |  |
| **Authorised representative information** |
| Name: |  |
| Job title: |  |
| Contact details: |  |
| Evidence of authorisation: | [ ]  | Trade register extract or power of attorney 3) | [ ]  | copy of official nomination decree 4) |
| Trade register extract number2) |  |
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| **IT Service Provider information** |
| Company name: |  |
| Postal address: |  |
| E-mail address: |  |
| Business ID: |  |
| Contact person: |  |
| Trade register extract number2) |  |

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| **Software identification** |
| Software name and version: 5) |  |

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| **MAIN CLIENT CONTAC PERSON – Contact who will be responsible to receive the credentials to access the system and will manage the users** |
| E-mail address: |  | Name: |  |
| Role: |
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| **Reason for the request** |
|  |
| **Name of the requestor** | **Date** | **Signature** |
|  |  |  |

1) License number granted by INFARMED

2)  To allow consultation on <https://bde.portaldocidadao.pt/evo/Services/Online/Pedidos.aspx?service=CCP>. Applicable to private entities

3)  Applicable to private entities

4) Applicable to public entities

5) Software used by the entity to connect to PTMVS

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| **REQUEST APPROVAL – To be completed by MVOPT manager** |
| **Name of MVOPT manager** | **Date** | **Signature** |
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| **REQUEST COMPLETION – To be completed by the system administrator** |
| Account ID: |  | Completion date: |  |
| Action performed: |
|  |

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| --- | --- | --- |
| **Name of the system administrator** | **Date** | **Signature** |
|  |  |  |