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| **REQUEST – To be completed by the representative of the company** |
| **System Name** | **Finnish Medicines Verification System (FiMVS)** |
| **Request Type (please fill all the necessary information)** |
|[ ]  New account (new place of business) | Valid from (dd.mm.yyyy): |  |
| [ ]  | Retire account (place of business closes permanently) | Valid from (dd.mm.yyyy): |  |
| [ ]  | Relinquish a pharmacy (contract with FiMVO expires) | Valid from (dd.mm.yyyy): |  |
| [ ]  | Take possession of a pharmacy | Valid from (dd.mm.yyyy): |  |
| [ ]  | Change of software | Installation date for the new software (dd.mm.yyyy): |  |
|  |  | Installation time for the new software (hh:mm): |  |
|  |  | Name of the current software: |  |
| [ ]  | Other change | Valid from (dd.mm.yyyy): |  |
| **Company information** |
| Company name: |  |
| Postal address: |  |
| Email address: |  |
| Phone number: |  |
| Type of end user: | [ ]  | Pharmacy | [ ]  | Hospital Pharmacy |
|  | [ ]  | Dispensary | [ ]  | Wholesale company |
| Business ID: |  |
| KELA ID: 1) |  |
| WDA authorisation number: 2) |  |
| **Authorised representative information** |
| Name: |  |
| Job Title: |  |
| E-mail address & Phone number: |  |
| Evidence of authorization: 3) | [ ]  | Pharmacy license | [ ]  | Hospital pharmacy license |
|  | [ ]  | Dispensary license | [ ]  | Trade register extract 2) |
| **IT Service Provider information** 4) |
| Company name: |  |
| Postal address: |  |
| Email address: |  |
| Contact person (name and phone number): |  |
| Name of software: |  |

1) Pharmacies

2) Wholesale companies

3) Evidence of authorization must be provided for a new account (new place of business)

4) Information regarding the new software and the new service provider, if the software changes

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| **Name of the requestor** | **Date** |
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| **REQUEST APPROVAL – To be completed by FiMVO manager** |
| Documentation reviewed and approved: |
| [ ]  | Agreement for the use of the Finnish Medicines Verification System by end users |
| [ ]  | Evidence of authorization |
| [ ]  | Access Request Form |
| **Name of FiMVO manager** | **Date** |
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| **REQUEST COMPLETION – To be completed by the system administrator** |
| Account ID: (i.e. PHARMACY/0999): |  |
| Action performed: |
| [ ]  | Account created in FiMVS | Date |  |
| [ ]  | Account information updated in FiMVS | Date |  |
| [ ]  | New certificate created | Date |  |
| [ ]  | Password renewed and sent to the user / IT service provider | Date |  |
| [ ]  | Other action, what:  | Date |  |
| **Name of the system administrator** | **Date** |
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