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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

|  |  |
| --- | --- |
| **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** |
|  | | | |  |