**Prescribing Doctor’s Details**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Telephone Number | Click or tap here to enter text. |
| E-mail Address | Click or tap here to enter text. |
| Licensing Country | Click or tap here to enter text. |
| Registration Number | Click or tap here to enter text. |

**Medical Facility Delivery Address Details\*\***

|  |  |
| --- | --- |
| Medical Facility Name | Click or tap here to enter text. |
| Contact Person (This must be a contact at the Medical Facility) | Click or tap here to enter text. |
| Telephone Number | Click or tap here to enter text. |
| E-mail Address | Click or tap here to enter text. |
| Street, House Number | Click or tap here to enter text. |
| City | Click or tap here to enter text. |
| Postal Code | Click or tap here to enter text. |
| Country | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Requested Medicine | Cufence 200 (100 capsules / bottle) |
| Type of Request | [ ] First request  | [ ] Repeat request |
| Number of Bottles Requested | Click or tap here to enter text. |
| Number of patients to be treated | Click or tap here to enter text. |

Request Date: Doctor’s Signature + Stamp:

Click or tap to enter a date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form, once completed, **must be signed and stamped** by an authorized medical professional. Please send this form along with the required documents as stated in the Donation Programme Leaflet to: prescription.medicines@univarsolutions.com

\*\*By signing this document, I am aware that the consignee is responsible for receiving the medicine, which must be appropriately and safely stored between 2 °C to 8 °C.

MEDICINE DONATED MUST NOT BE RE-EXPORTED OR TRANSFERRED IN EXCHANGE FOR MONEY, OTHER PROPERTY, OR SERVICES.

Disclaimer: Univar collects and retains this data for the purposes of this donation programme in accordance with legal requirements.