



This form shall be filled out by the supplier and **included in the invoice!!!**

See letter head for billing address!-
Otherwise payment will not be possible.

1 Device master data – Version for operator files

ID-No.: _____
(issued by hospital!)

Device designation: _____ Year built: _____
Model/Type: _____ Serial No.: _____

Manufacturer's entry :
or responsible agent in EU

Name: _____	
Street: _____	
Zip/City: _____	
Name and telephone number for the safety expert pursuant to §30 Med Prod. Law.: _____	
Servicing (periodic inspections):	
<input type="checkbox"/> Safety inspections	every _____ months
<input type="checkbox"/> Measurement inspections	every _____ months
<input type="checkbox"/> ICE 62353	every _____ months
<input type="checkbox"/> Maintenance	every _____ months
<input type="checkbox"/> None	
Please include a supplement for the scope and times of the periodic inspections!	
Number of supplements (esp. accident prevention): _____ <input type="checkbox"/> none	

Manufacturer's entry :
or responsible agent in EU

2 Classification (Med Prod Law):

Non-medical use / General lab equipment:

CE for EMV: yes no

Please enter only one cross- MP / IVD / non-med. use
Include appropriate certificate/ permit

Medical use:

MP: I IIa IIb III IVD:

3 Data on submission and initial instruction:

Only necessary for Med Prod. Law devices
Amendment 1 (Operational ord.)!

Functional test for initial commissioning was performed on: _____

by: _____ Signature: _____
Supplier, name

Whereby the instruction manual in the German language was given to the person responsible for the device or their representative _____.

The following people were briefed in the use of the device based on the instruction manual by _____.
Instructor, name and function

Names of people briefed: <small>(Block letters !)</small>	Signature of people briefed:

4 Signature of medical product advisor: _____

Certifies completeness of entries, especially regarding the periodic inspections

The contract is only considered fulfilled after all information is entered!

Hospital: _____ Station/ward: _____ Cost center: _____
(Entered by hospital)