Steroplast Healthcare

Customer Qualification / Re-Qualification Form

CUSTOMER QUALIFICATION/ RE-QUALIFICATION

Customer Name

Corporate Address (incl. Postcode)

Delivery Address (incl. Postcode)

Contact Person

Name

Phone

Email

Customer Type

☐ Hospital ☐ Pharmacy ☐ Wholesale Distributor ☐ Healthcare Professional ☐ Pre-wholesale Distributor

Other (Please specify)

Product Categories

☐ GSL (4.2) ☐ P.O.M (4.1) ☐ Pharmacy (4.4) ☐ Medical Devices

Other (Please specify)

QUALIFICATION STATUS - for office use only

Select Status

Qualified

Conditionally Qualified
(Please add reason below)

Disqualified
(Please add reason below)

Reason

APPROVALS - for office use only

QA Personnel

Name

Signature

Date

Re-Qualification Due Date

Added to Approved Customer Index

Yes

No

Comments

Date

Added to Approved Customer Index by

Name

Signature

Date

Customer Type

Required for Customer Type	Qualification Criteria	Results / Comments
Yes ☐ No ☐	**Local Regulatory Authority**	MHRA ☐ Other (Please specify) _____ Date Verified _____
Yes ☐ No ☐	**Wholesale License**	Licence # _____ Date Granted _____ Date Expires _____
	Certified English Translation	Yes ☐ No ☐ N/A ☐ Date _____
	MHRA-GMDP Website	Yes ☐ No - Please give reason _____ Date _____
Yes ☐ No ☐	**GDP Certificate**	Certificate # _____ Other proof of GDP compliance _____ Date Granted _____ Date Expires _____
	Certified English Translation	Yes ☐ No ☐ N/A ☐ Date _____
	MHRA-GMDP Website	Yes ☐ No - Please give reason _____ Date _____

Required for Customer Type	Qualification Criteria	Results / Comments
Yes ☐ No ☐	**Other License**	Type of Licence Licence # Date Granted Date Expires **Certified English Translation:** Yes ☐ No ☐ N/A ☐ Date
Yes ☐ No ☐	**Temperature Mapping to Customer Required**	Yes ☐ No ☐ If "Yes", notify Operations Director
Yes ☐ No ☐	**Authority Website Hospital/ Pharmacy/ Healthcare Professional/ Other Details**	Details Date of Verification **Independent Confirmation of Address Obtained** Yes ☐ No ☐ Date Details

PRESCRIPTION ONLY MEDICINES (P.O.M) & PHARMACY PRODUCTS (P)

Medicines Act S.1.1921: 1980 SP1317 Issue 3 Appendix 1 | Date: February 2019

Account Number	
Date	
First Name	
Surname	
Practice/ Company Name	
Address (incl. Postcode)	
PIN Number	
Expiry Date	
Qualification	
Nurse/Paramedic DOB	
Specimen Signature	

GMC/GDC Number	
First Name	
Surname	
Signature	