**Application for waiver/refund of reimbursement of costs pursuant to the Act on Pharmaceuticals and the Act on Human Tissues and Cells**

For clear identification of your request, please complete all the fields!

|  |  |
| --- | --- |
| Application file no.  |  |
| Marketing authorisation number\*) |  |
| Procedure no.\*\*) |  |
| Expert activity (for categories, see UST-29): |  |
| Code (see UST-29): |  |
| Product name (for MA-related applications):  |  |
| Content of the application |  |
| Applicant’s name: |  |
| Applicant’s address: | Street, PO Box: | Town, Postcode, State: |
| Contact person: |  |
| Contact person’s address: |  | Phone, email: |
| Amount to be refunded (in CZK): |  | Date of payment: |
| Variable symbol of the application\*\*\*) |  | Requested currency of refund: |
| Name of Applicant’s bank: |  | Address: |
| Account no/bank code:  |  | IBAN: |
| SWIFT: |  | National clearing code – if known: |
| Rationale: |  |
| Link to sources where the claim can be verified: |  |

*\*) Please state the marketing authorisation number in case of requests for the refund of the annual maintenance fee, or for the refund of reimbursements of costs of any procedure relating to a previously authorised medicinal product*

\*\*) *Procedure number in case of mutual recognition procedures*

*\*\*\*) Variable symbol specified in the “Proof of Payment of Cost Reimbursement” document*

 Date Applicant’s name and signature

## Please do not fill in – for Institute’s internal purposes:

Position of the unit carrying out the expert activity on the rationale stated in the application: …………….

With a view to the aforementioned, I consent/do not consent to the refund of: CZK ……………………………

Date Name and signature of the operation’ mandator