**Application for refund of reimbursement of costs pursuant to the Act on Medical Devices an Act on In Vitro Diagnostic Medical Devices**

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

|  |  |
| --- | --- |
| Application file no. |  |
| Expert activity (for categories, see UST-29): |  |
| Code (see UST-29): |  |
| Name of the assessed product: |  |
| 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\*\*: |
| Rationale: |  |

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

*\*\*) If known*

 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