

# PHYSICIAN'S STATEMENT

*Permission for the delivery/supply of unlicensed medicines.*

Undersigned:

Name and initials physician	
Specialism (when relevant)	
Address Stamp	
Telephone number	

Hereby states:

- a) That his/her patient \_\_\_\_\_ (name or code number) suffering from / for prevention of \_\_\_\_\_ cannot be adequately treated with the nationally available medicines. Therefore (s)he wishes to have the following medicine to his/her disposal for the treatment of his/her patient: \_\_\_\_\_
- b) That (s)he is aware that there is currently no market authorisation for this medicine in \_\_\_\_\_ (country). Consequently the medicine has not been tested on efficacy, toxicity or validity as stated in the National Medicines Act. (S)He has explicitly stated this to the patient or his/her legal guardian.
- c) That (s)he carries the full responsibility and accepts the risk of treating the patient(s) with this medicine.
- d) That (s)he will notify the responsible authorities (i.e. Health Inspection) of known symptoms that occur during treatment and where it is suspected that they are caused by the medicine.

Place	Date <sup>1</sup>	Signature Physician
.....	.....	.....

<sup>1</sup> This statement will remain valid until one year after signing.