MALTA MEDICINES AUTHORITY

For office use only:

Clinical Investigation – Application / Notification form under the Medical Device Regulation received on:

Clinical Investigation – Application / Notification form under the Medical Device Regulation Reference No.

MT-MDF15

Clinical Investigation – Application/Notification form under the Medical Devices Regulation (EU) 2017/745

The application is valid when submitted with the relevant documents and fees, where applicable.

Relevant correspondence should reach the Authority via Email address mdforms.medicinesauthority@gov.mt.

Refer to GL-MDF07 Guidance on fees in relation to Medical Devices. Guidance and Application Form are available on the Malta Medicines Authority website www.medicinesauthority.gov.mt.

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www.medicinesauthority.gov.mt

SECTION A: APPLICATION INTRODUCTION & APPLICANT DETAILS

A.1 Date of Application (dd/mm/yyyy): *Name & Surname:* *Email Address:* *Contact Number:*
A.2 Applicant (tick as applicable) ☐ Sponsor (within the Union): Fill in Section B ☐ Legal Representative (when Sponsor is outside the Union): Fill in Section C

SECTION B: SPONSOR CONTACT DETAILS

Organisation Name:	Telephone Number:
Address:	Contact Name:
	Job Title:
	Email address:
If Organisation is registered with the Authority, quote reference number	

SECTION C: LEGAL REPRESENTATIVE CONTACT DETAILS

Organisation Name:	Telephone Number:
Address:	Contact Name:
	Job Title:
	Email address:
If Organisation is registered with the Authority, quote reference number	

SECTION D: MANUFACTURER AND AUTHORISED REPRESENTATIVE CONTACT DETAILS

Organisation Status (tick as applicable):

☐ Manufacturer (fill in Section D.1)

☐ Authorised Representative (fill in Sections D.1 &D.2)

D.1 MANUFACTURER CONTACT DETAILS

Organisation Name:	Telephone Number:
Address:	Contact Name:
	Job Title:
	Email address:
If Organisation is registered with the Authority, quote reference number	

D.2 AUTHORISED REPRESENTATIVE CONTACT DETAILS

Organisation Name:	Telephone Number:
Address:	Contact Name:
	Job Title:
	Email address:
If Organisation is registered with the Authority, quote reference number	

SECTION E: NOTIFIED BODY CONTACT DETAILS

Identification Number:
If other notified bodies are involved, quote Identification Number/s

SECTION F: INVESTIGATOR CONTACT DETAILS

Name:	Telephone Number:
Job Title:	
Email address:	
Healthcare Institution:	

SECTION G: APPLICATION / NOTIFICATION FORM (EU)

Refer to the MDCG 2021-08 guidance in the Clinical Investigation and Evaluation section.

Documentation in attachment:

☐ Filled in relevant forms

☐ Supporting documents

SECTION H: DETAILS OF PAYMENT

☐ Proof of Payment attached

SECTION I: DATA PROTECTION CONSENT STATEMENT

☐ *The applicant hereby consents to the processing of their personal data by the Malta Medicines Authority and understands that this data shall be processed in accordance with the General Data Protection Regulation (GDPR), Regulation 2016/679/EU of the European Parliament and of the Council of 27 April 2016, the Data Protection Act (Chapter 586 of the Laws of Malta) and the Malta Medicines Authority Data Protection Policy (P-MA05). The applicant also understands that the Malta Medicines Authority shall process this personal data in line with the purposes they are initially collected for. Exceptions to the latter include when the data subject consents to the new purpose, when there is a legal provision requiring or allowing the new processing or when the new purpose is deemed compatible with the purposes the personal data were initially collected for.*

Malta Medicines Authority Declaration for Form Submission

I, the applicant, declare that all information given in the application form is true, complete and correct. I also bind myself to inform immediately any change to details in the application form and annexes, where relevant, to the Malta Medicines Authority.

Company Name (if applicable):

Name & Surname:

Position:

Signature:

Date: