* This form should be submitted along with the relevant **documents.**
* The form and attachments should be emailed to **medicaldevices.services@bomra.co.bw** **and** **rmu@bomra.co.bw**

|  |  |  |
| --- | --- | --- |
| **S/N** | **Title** | **To be completed by the stakeholder** |
|  |
|  | **Local Representative/Importer/Distributor/Agent/Facility** |  |
| 1.1. Name | Stakeholder’s Name. |  |
| 1.2. Physical address  |  Full physical address  |  |
| 1.3. Phone number |  |  |
| 1.4. Email address |  |  |
|  | **Manufacturer of the Product (Please fill in Annexure I)** |  |
|  | **Details of the Product (Please fill in Annexure I)** |  |
|  | **Declaration by Stakeholder** |  |
| I, the undersigned, certify that all the information above is correct and true. |  |
| Name of Contact Person | Click or tap here to enter text. |  |
| Position in company |  Click or tap here to enter text. |  |
| Date: |  Click or tap to enter a date. |  |
| Signature (Initials / Digital) |    |  |
|  |