Application for participation in the Swedish Pharmaceutical Insurance

Our company hereby acknowledge our wish to participate in the Swedish Pharmaceutical Insurance and hence become a shareholder in LFF Service AB.

Company name:……

Company adress:……

……

VAT number / Company registration number:
……

Contact person: Name, Phone, Email:……..

……..……..

Place and date:……

Authorised representative of the
Company:……...

Clarification of signature and
title:……

<u>Our company business is:</u>

- ☐ Manufacturing and/or Sales
- ☐ Research & Development (clinical trials)
- ☐ Distributor, Retailer
- ☐ CRO (Clinical Research Organisation)

<u>If - Sales and/or manufacturing or distributor/retailer - please give information of pharmaceuticals sold in the Swedish market</u>:

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If - R&D, please provide the following information:

ID No for each clinical trial (study):

……

The study is approved by the Swedish Medical Products Agency
And/or will be send to the Etichs Committee in:……

Number of patients involved in the study
during present calendar year……

The study concerns PHASE:……

The study is to be finalized ÅÅÅÅMM:……..

If – CRO please provide following information:

During present calender year number of
patients involved in studies where the
sponsor is not participating in
the Swedish Pharmaceutical insurance:……..

Please send to:

LFF Service AB
Box 17608
SE-118 92 Stockholm
Sweden

E-post: info@lakemedelsforsakringen.se