Ministry of Health and Social Services

PHARMACEUTICAL PRODUCTS QUALITY REPORTING FORM

Name of facility		Telephone	
Dispensing facility		Date of Report	DD/MM/YYYY

PRODUCT IDENTITY

Brand name/ manufacturer		Batch / Lot Number	
Generic name		Date of manufacture	DD/MM/YYYY
Country of origin		Expiry date	DD/MM/YYYY
Supplier/ Distributor		Date of receipt	DD/MM/YYYY

PRODUCT FORMULATION (Tick appropriate box)	**COMPLAINT (Tick appropriate box(es))**
□ Oral tablets/capsules □ Oral suspension/syrup □ Injection □ Diluent □ Powder for reconstitution of suspension □ Powder for reconstitution of injection □ Eye drops □ Ear drops □ Nebulizer solution □ Cream/Ointment/ Liniment □ other /specify……..	□ Colour change □ Separating of phases □ Powdering / Crumbling □ Moulding □ Change of odour □ Mislabelling □ Incomplete pack □ Other / specify

Describe quality complaint in detail

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Storage conditions

Does the product require refrigeration?	□ Yes	□ No	(other details if any)
Was the product dispensed and returned by a patient?	□ Yes	□ No	
Was the product stored according to manufacturer recommendation?	□ Yes	□ No	

Comments (if any)

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Name of person reporting		Contact number	
Job Title		Signature	

This information is supplied for the improvement of medicine quality, safety and efficacy in Namibia

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