REF NO

Annex 2

IVD TEST/ASSAY EVALUATION APPLICATION FORM

No.	*Mandatory Information to Be Filled*	
1	**Applicant**	
	Company Name:	
	Contact Person:	
	Address:	
	Email:	
	Tel. No.:	
2	MDA Letter if applicable (*Date /Ref. No.*):	
3	**Product Info**	
	Product Name:	
	Manufacturer:	
	Lot Number:	
	Identifier/ REF/ Batch / Ref No:	
	Detection Method & Intended Use:	*Please attach IFU*
	Expiry Date:	
	Sample Type:	
	Size of Packaging:	
	Recommended storage conditions:	
	Test Controls (yes/no)	
	Calibrators (yes/no)	
	Consumables (if yes- to specify)	
	Purpose of evaluation	

Note:

1. Please provide extra kits for troubleshooting (20 for COVID-19 rapid test kits and more FOR ELISA/ molecular test/assay), no analysis charge required for extra IVD Test/Assay
2. Please pay within two weeks from invoice received in order to start the evaluation test. If failed to do so, invoice will be cancelled and IVD Test/Assay must be taken back by applicants. PAYMENTS ARE NON-REFUNDABLE.
3. Report will be available after three months from evaluation started. Extra IVDTest/Assay shall not to be returned to applicants.

**This section is for MKAK usage:*

RECEIPT OF IVD TEST/ASSAY

IVD Test/Assay	Method	Quantity charged	Quantity received
COVID-19	RTK Ag	Nasal: 60 Saliva :60 NPS/OPS :100	
	RTK Ab	100	
	RTKAb Neutralizing	60	
	Molecular	60	
	ELISA	100	
Non-COVID-19		Based on needs	

One copy of this form to be sent to laboratory

Tech Officer:
Date kit received:
_____
Report No:
Invoice no:
Payment date:
Result:
Report date:

Condition on Receipt: (Dry Ice/ Ice/ No Ice/ Cold/ RT/ Warm)

	Requestor	Receiver (MKAK Officer)
Name:		
Designation:		
Date:		
Signature:		