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| **Medsafe consultation submission**  |

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| **Consultation on the revision of CMN Form B** |

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| Name and designation |       |
| Company/organisation name and address |       |
| Contact phone number and email address |       |
| I would like the comments I have provided to be kept confidential: *(Please give reasons and identify specific sections of response if applicable)*     (Reasons for requesting confidentiality must meet [Official Information Act 1982](http://www.legislation.govt.nz/act/public/1982/0156/latest/DLM64785.html?search=qs_act_official+information+act_resel_25_h&p=3&sr=1) criteria) | [ ]  Yes [ ]  No |
| I would like my name to be removed from all documents prior to publication on the Medsafe website | [ ]  Yes [ ]  No |
| I do not wish my name to be associated with my company/organisation. | [ ]  Yes [ ]  No |

**It would help in the analysis of stakeholder comments if you provide the information requested below.**

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| I am, or I represent, a: *(tick all that apply)* |
| [ ]  Importer | [ ]  Manufacturer | [ ]  Supplier | [ ]  Sponsor |
| [ ]  Government | [ ]  Researcher | [ ]  Professional body | [ ]  Industry organisation |
| [ ]  Consumer organisation | [ ]  Member of the public | [ ]  Institution (e.g. university, hospital) |
| [ ]  Regulatory affairs consultant | [ ]  Laboratory professional |  |  |
| [ ]  Health professional – *please indicate type of practice*:       |
| [ ]  Other - *please specify*:       |

**Please return this form to:**

**Email: medsafeapplications@moh.govt.nz** and include **Consultation on the revision of CMN Form B** in the subject line

**Or Post:** Product Regulation

 Medsafe

 PO Box 5013

 Wellington 6145

**Medsafe is seeking comments on:**

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| The changes proposed to CMN Form B. |
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| Additional Comments |