



**MEDICAL DEVICES AND IN VITRO  
DIAGNOSTICS ADVERSE EVENT/INCIDENT  
REPORTING FORM FOR CONSUMERS AND  
HEALTH FACILITIES**

*For TMDA internal use only*      **Report Number:** \_\_\_\_\_      **Date received:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**1. DEVICE DETAILS**

Full name (Brand and Common):	Size (if applicable):
Manufacturing date: ____/____/____	Serial number:
Expiry date: ____/____/____	Batch number/lot number:
Manufacturer name and address:	
Source of device. Please (√) where required: <input type="checkbox"/> Hospital <input type="checkbox"/> Store <input type="checkbox"/> Other	Name of the supplier and address:
Status of the device. Please (√) where required: <input type="checkbox"/> New device <input type="checkbox"/> Re-serviced/refurbished	
Current location of the device:	

**2. EVENT/INCIDENT DETAILS**

Onset date of event/incident: ____/____/____
Type of Event (user related): Please (√) where required: <input type="checkbox"/> Death <input type="checkbox"/> Life threatening <input type="checkbox"/> Caused persistent disability or incapacity <input type="checkbox"/> Required or prolonged hospitalization <input type="checkbox"/> Other, please give details:
Event description narrative (explain what went wrong):
Number of patients involved:
Type of incident (device related): Please (√) where required: <input type="checkbox"/> Inadequate design <input type="checkbox"/> Inaccurate labeling/instruction for use <input type="checkbox"/> Malfunction <input type="checkbox"/> Deterioration <input type="checkbox"/> Other, please give details:
Incident description narrative (explain what went wrong with the device):
Number of medical devices involved:
How long the device has been in use: <input type="checkbox"/> Less than six (6) months <input type="checkbox"/> Less than one (1) year <input type="checkbox"/> 1-5 years <input type="checkbox"/> Others, Explain:



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Operator at the time of event/ incident. Please (√) where required:  Medical practitioner  Other,  
*Please give details:*

Measures taken by the user:

Have you informed the supplier? *Please (√) where required:*  Yes Date: \_\_\_\_\_  No

**3. REPORTER DETAILS**

Name of Reporter or Initials:

Address:

District/Region/City:

Email:

Telephone/Mobile phone:

Date of report: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Send to:**

The Director General,  
Tanzania Medicines and Medical Devices Authority  
(TMDA),  
P.O.Box 1253,  
Dodoma, Tanzania

**OR**

P.O.Box 77150,  
Dar Es Salaam, Tanzania  
Tel: +255 22 2450512 / 24507551  
Email: [info@tmda.go.tz](mailto:info@tmda.go.tz)  
Website: [www.tmda.go.tz](http://www.tmda.go.tz)  
Toll free number: 0800110084