MEDICAL DEVICES AGENCY

COMPETENT AUTHORITY (UK)

MEDICAL DEVICES REGULATIONS 1994: REGULATION 14
FORM RG2

REGISTRATION OF PERSONS RESPONSIBLE FOR PLACING DEVICES ON THE MARKET

PART 1: *About the Notification*

Please read the accompanying guidance notes before commencing.
Please complete in type face or block letters. The form may be copied if required.

COMPETENT AUTHORITY USE ONLY

File Reference Number

Date Received

1 Enter the date of notification.

Day	Month	Year
24	04	98

2 Please indicate if this is the first, further, or change of information.

First	Further	Change
✓		

If further or change please provide previous reference number.

Previous Reference Number CA ----------

3 Please indicate the status of the organisation making this registration notification by ticking the appropriate box.

Manufacturer	Authorised Representative	Assembler of System and procedure packs (Regulation 11 / Article 12)	Other
✓			

4 The statement opposite must be completed by an authorised signatory of the manufacturer, authorised representative, or other organisation responsible for placing the device(s) on the market. (see guidance notes).

I, (*please print full name*) J. S. LAMB

affirm that the information provided in this notification is accurate and that the Class I devices / Custom-made devices / System and procedure packs (Regulation 11 / Article 12) (please delete as appropriate) covered by this notification meet the provisions of the Regulations which apply to them.

Signed J S Lamb Date 24-04-98

Position MANAGING DIRECTOR

Company Name VIAMED LTD.

PLEASE SEND COMPLETED FORM TO: Mr.S.Williams, Medical Devices Agency, 11/S/13 Hannibal House, London, SE1 6TQ.

PART 2: *Manufacturer Information*

Tick this box if you are notifying a change of name or address. ☐

UK ADDRESS

5 Enter the full name and postal address of the manufacturer, or person responsible for placing the device(s) on the market, if based in the UK. (This relates to the address information on the labelling or packaging).

Manufacturers name or person responsible

VIAMED LTD.

Address

15 STATION RD
CROSS HILLS
KEIGHLEY
WEST YORKSHIRE
BD20 7DT

*Telephone and facsimile number

Telephone 01535634542 Facsimile number

MANUFACTURER'S ADDRESS IF OUTSIDE EC

* Enter the full name and postal address of the manufacturer if based outside the EC. (This relates to the address information on the labelling or packaging).

Manufacturers name

Address

*Telephone and facsimile number including international codes.

Telephone Facsimile number

*DENOTES INFORMATION WHICH IS ADDITIONAL TO DIRECTIVE REQUIREMENTS

PART 3: *Device Information*

6 *Enter details of Notified Body approval of quality system for sterilisation or measuring function relevent to the device(s).

Notified Body Identification Number	Covering

CLASS I DEVICE(S) COMPLETE 7 OR 7A

7 Please refer to list of product codes and note generic family group code letter(s). If none appear appropriate, enter your generic name(s) at 7a below.

Generic Code Name(s)

7a Enter your generic name(s) of devices. More than one group may be registered providing all other information within the form applies.

Generic Name(s)

HEADBOXES - LIGHTSHIELDS

OXYGEN THERAPY CHAIR

COT LIDS

VENTILATOR TUBE HOLDERS

PLEASE COPY IF ADDITIONAL PAGES ARE REQUIRED

FOR CUSTOM-MADE DEVICE(S) AND/OR SYSTEM AND PROCEDURE PACKS SEE OVER.