GILEAD	Solicited Program Adverse Event/Special Situation Report Form	GF-21045H.03

Please complete as many details as possible and forward within one business day to:

Program Details

Name of Program:	HCV Elimination Project
Name of Organisation:	Ministry of Labour, Health and Social Affairs of Georgia
Date aware of Safety Information:	29.10.15
Country of Occurrence of Safety Information	Georgia

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	g. ხათელიშვილი
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age: 60 | Initials: CM | Sex: Male ☑ Female ☐ | DOB: 20/09 (or year of birth): 1955

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	27/08/15	17/09/15	Chronic HepC	PWMKD
Ribavirin	600mg	PO	27/08/15	17/09/15	Chronic Hep C	FM E2791
Interferon	180mg	Inj	27/08/15	17/09/15	Chronic Hep C	47RB 70304

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse Event, Cardiac Disease

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

If the Reporter is a Healthcare Professional (HCP) and they are willing to provide us with their contact information, please record below

**If the Reporter is a Non-healthcare professional, please confirm if they are willing to provide contact information for their HCP:*

Yes ☐ (Please record details below) No ☐

HCP Name:	**HCP Address**
HCP Telephone No/FAX No:	First Line:
HCP Email:	Town/City:
	County/State:
	Postcode/Zip code:

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Country of Occurrence of Safety Information	Georgia

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	G. Khatelishvili
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age: 62 | Initials: S A | Sex: Male ☑ Female ☐ | DOB: 01/02 (or year of birth): 1953

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	24/08/15	15/10/15	Chronic Hep C	PWM15D
Rebetol	200mg	PO	24/08/15	15/10/15	Chronic Hep C	5RCJA87 A01

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse event, Portal vein thrombosis

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐

Has this safety information previously been reported to a Regulatory Authority? Yes ☐ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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GILEAD	Solicited Program Adverse Event/Special Situation Report Form	GF-21045H.03

Please complete as many details as possible and forward within one business day to:

Program Details

Name of Program: HCV Elimination Project	Form Completed By
Name of Organisation: Ministry of Labour, Health and Social Affairs of Georgia	Print Name: Giorgi Khatelishvili
Date aware of Safety Information: 29.10.15	Signature: [signature]
Country of Occurrence of Safety Information: Georgia	Telephone Number: +995598708807
	Fax No/Email: Gkhatelishvili@moh.gov.ge

Patient Details

Age: 70 **Initials:** M G **Sex:** Male ☑ Female ☐ **DOB:** 13/02 (or year of birth): 1940

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	31/07/15	03/09/15	Chronic HepC	PWMSD
Ribavirin	200mg	PO	31/07/15	03/09/15	Chronic HepC	N0338B08

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse Event, wealeness

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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Yes ☐ (Please record HCP details below) No ☐

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GILEAD	**Solicited Program Adverse Event/Special Situation Report Form**	**GF-21045H.03**

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Program Details

Name of Program: HCV Elimination Project	Form Completed By
Name of Organisation: Ministry of Labour, Health and Social Affairs of Georgia	Print Name: Giorgi Khatelishvili
Date aware of Safety Information: 29.10.15	Signature: [signature]
Country of Occurrence of Safety Information: Georgia	Telephone Number: +995598708807
	Fax No/Email: Gkhatelishvili@moh.gov.ge

Patient Details

Age: 78 | Initials: K2 | Sex: Male ☑ Female ☐ | DOB: 21/01 (or year of birth): 1939

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	03/08/15	07/09/15	Chronic HepC	PWMKD
Ribavirin	200mg	Po	03/08/15	07/09/15	Chronic HepC	FGE 2861

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Serious Adverse Event, Hospitalization, due to extrahepatic manifestation

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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**If the Reporter is a Non-healthcare professional, please confirm if they are willing to provide contact information for their HCP:*

Yes ☐ (Please record HCP details below) No ☐

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Program Details

Name of Program: HCV Elimination Project	Form Completed By
Name of Organisation: Ministry of Labour, Health and Social Affairs of Georgia	Print Name: Giorgi Khatelishvili
Date aware of Safety Information: 26.10.2015	Signature: [signature]
Country of Occurrence of Safety Information: Georgia	Telephone Number: +995598708807
	Fax No/Email: Gkhatelishvili@moh.gov.ge

Patient Details

Age: 50 | Initials: M G | Sex: Male ☑ Female ☐ | DOB: 15/01 (or year of birth): 1965

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	29/05/15	24/08/15	Chronic Hep C	P15YBD
Ribavicin	200mg	PO	29/05/15	24/08/15	Chronic Hep C	N0338B08

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death, include the date of death – continue on another page if necessary.

Adverse event, Anemia

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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**If the Reporter is a Non-healthcare professional, please confirm if they are willing to provide contact information for their HCP:*

Yes ☐ (Please record HCP details below) No ☐

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Date aware of Safety Information:	29.10.15
Country of Occurrence of Safety Information	Georgia

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	ჯ. ხათელიშვილი
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age:	Initials:	Sex:	DOB:
49	BS	Male ☑ Female ☐	27.01 (or year of birth): 1967

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	20/08/15	03/09/15	Chronic HepC	PWMKD
Interferon	180mg	Inj	20/08/15	03/09/15	Chronic HepC	1906-05
Ribavirin	200mg	PO	20/08/15	03/09/15	Chronic HepC	FGE-2561

Safety Information Details:

Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and, for reports of death include the date of death – continue on another page if necessary.

Adverse event, Cardiac problems

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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Name of Organisation:	Ministry of Labour, Health and Social Affairs of Georgia
Date aware of Safety Information:	29.10.15
Country of Occurrence of Safety Information	Georgia

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	[signature]
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age: 67 | Initials: TT | Sex: Male ☑ Female ☐ | DOB: 15/01 (or year of birth): 1948

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	30/07/15	07/09/15	Chronic HepC	PNMKD
Interferon	180mg	Inj	30/07/15	07/09/15	Chronic HepC	1907-1
Ribavirin	200mg	PO	30/07/15	07/09/15	Chronic HepC	FGE2560

Safety Information Details:

Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse event, stoped taking drug with his own will

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☐ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☐ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

If the Reporter is a Healthcare Professional (HCP) and they are willing to provide us with their contact information, please record below

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Yes ☐ (Please record HCP details below) No ☐

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Name of Organisation: *Ministry of Labour, Health and Social Affairs of Georgia*	Print Name: Giorgi Khatelishvili
Date aware of Safety Information: 29.10.15	Signature: G. Khatelishvili
Country of Occurrence of Safety Information: *Georgia*	Telephone Number: +995598708807
	Fax No/Email: Gkhatelishvili@moh.gov.ge

Patient Details

Age: 39 | Initials: PG | Sex: Male ☑ Female ☐ | DOB: 13/07 (or year of birth): 1976

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	13/07/15	21/09/15	Chronic Hep C	PWMBD
Ribavirin	200mg	PO	13/07/15	21/09/15	Chronic Hep C	FME2791

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

SAdverse Event, Pulmonary Tuberculosis

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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Yes ☐ (Please record HCP details below) No ☐

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Date aware of Safety Information:	29.10.15
Country of Occurrence of Safety Information	*Georgia*

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	[signature]
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age:	Initials:	Sex: Male ☐ Female ☐	DOB: (or year of birth):

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	03/06/15	30/06/15	Chronic HepC	SFMTD
Ribavirin	200mg	Po	03/06/15	30/06/15	Chronic Hep C	N0337B02

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Liver transplantation

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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Yes ☐ (Please record HCP details below) No ☐

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Date aware of Safety Information:	29.10.2015
Country of Occurrence of Safety Information	*Georgia*

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	[signature]
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age: 68 **Initials:** QT **Sex:** Male ☑ Female ☐ **DOB:** 2703 (or year of birth): 1947

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	13/07/15	25/09/15	Chronic HepC	PWMKD
Ribavirin	200mg	PO	13/07/15	25/09/15	Chronic HepC	FGE 2560

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse Event, Cardiac disease

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (I.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

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	County/State:
	Postcode/Zip code:

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GILEAD	Solicited Program Adverse Event/Special Situation Report Form	GF-21045H.03

Please complete as many details as possible and forward within one business day to:

Program Details

Name of Program:	*HCV Elimination Project*
Name of Organisation:	*Ministry of Labour, Health and Social Affairs of Georgia*
Date aware of Safety Information:	29.10.15
Country of Occurrence of Safety Information	*Georgia*

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	G. Khatelishvili
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age:	Initials: SL	Sex: Male ☑	Female ☐	DOB: 14/01	(or year of birth): 1961

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	17/06/15	Ongoing	Chronic Hep C	SFMTD
Interferon	180mg	Inj	17/06/15	Ongoing	Chronic Hep C	4RCA32A01
Ribavirin	200 mg	PO	17/06/15	ongoing	Chronic HepC	1906-3

Safety Information Details: Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse Event, Anemia

Does the Reporter consider that the event(s) were possibly related to the drug?	Has this safety information previously been reported to a Regulatory Authority?
Yes ☑ No ☐	Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

If the Reporter is a Healthcare Professional (HCP) and they are willing to provide us with their contact information, please record below

**If the Reporter is a Non-healthcare professional, please confirm if they are willing to provide contact information for their HCP:*

Yes ☐ (Please record HCP details below) No ☐

HCP Name:	**HCP Address**
HCP Telephone No/FAX No:	First Line:
HCP Email:	Town/City:
	County/State:
	Postcode/Zip code:

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Program Details

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Name of Organisation:	*Ministry of Labour, Health and Social Affairs of Georgia*
Date aware of Safety Information:	29.10
Country of Occurrence of Safety Information	*Georgia*

Form Completed By

Print Name:	Giorgi Khatelishvili
Signature:	[signature]
Telephone Number:	+995598708807
Fax No/Email:	Gkhatelishvili@moh.gov.ge

Patient Details

Age: 50 | Initials: X M | Sex: Male ☑ Female ☐ | DOB: 29/06 (or year of birth): 1965

Drug Details (Provide additional drugs on a separate page)

Drug Name	Dose	Route	Start Date (DD/MON/YYYY)	Stop Date (or On-going) (DD/MON/YYYY)	Reason For Taking	Lot/Batch No
Sovaldi	400mg	PO	22/06/15	14/07/15	Chronic HepC	PK4BD
Ribavirin	200mg	Po	22/06/15	14/07/15	Chronic HepC	4RCJA56A07
Interferon	180mg	Inj	22/06/15	14/07/15	Chronic HepC	1906-3

Safety Information Details

Please provide a short summary of the adverse event(s) (AE) or other safety information (e.g. reports such as pregnancy, death, hospitalization, overdose, misuse, abuse, medication error, lack of effect, off-label use, occupational exposure, AEs associated with product complaints or AEs in an infant following exposure from breastfeeding). Please include the start and stop dates and the outcome of the event(s) or confirm if the event(s) is/are still ongoing. Please also provide any treatment given to treat the event(s), any relevant medical history and for reports of death include the date of death – continue on another page if necessary.

Adverse Event, Subarachnoid haemorrhage

Does the Reporter consider that the event(s) were possibly related to the drug? Yes ☑ No ☐	Has this safety information previously been reported to a Regulatory Authority? Yes ☑ No ☐

Reporter Details (i.e. who notified you of the above safety information?)

Is the Reporter a: Doctor ☐ Nurse ☐ Pharmacist ☐ Non-healthcare professional (e.g. patient, relative)* ☐

If the Reporter is a Healthcare Professional (HCP) and they are willing to provide us with their contact information, please record below

**If the Reporter is a Non-healthcare professional, please confirm if they are willing to provide contact information for their HCP:*

Yes ☐ (Please record HCP details below) No ☐

HCP Name:	**HCP Address**
HCP Telephone No/FAX No:	First Line:
HCP Email:	Town/City:
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