



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

# MEDWATCH

## FORM 3500A

For use by user-facilities, importers, distributors  
and manufacturers for MANDATORY reporting

Form Approved: OMB No. 0910-0291

Expires: 6-30-2025

See PRA statement on page 6.

## FDA USE ONLY

Mfr report #

UF/Importer Report #

Exemption/Variance #

**Note:** For date prompts of "dd-mmm-yyyy" please use 2-digit day, 3-letter month abbreviation, and 4-digit year; for example, 01-JAN-1900.

## A. PATIENT INFORMATION

1. <b>Patient Identifier</b> ( <i>In confidence</i> )		2. Age		or Date of Birth ( <i>e.g., 01-Jan-1900</i> )
		Year(s)	Week(s)	
		Month(s)	Day(s)	
3. <b>Sex:</b> Enter the patient's sex at birth ( <i>the sex that a person has or was assigned to at birth</i> ).  Male  Female		SECTION REMOVED		
4. <b>Weight</b>  lb  kg	5. <b>Ethnicity</b> ( <i>Check one</i> )  Hispanic/Latino  Not Hispanic/Latino	6. <b>Race</b> ( <i>check all that apply</i> )  American Indian/Alaska Native      Native Hawaiian/ Asian      Other Pacific Islander Black or African American      White		

## B. ADVERSE EVENT OR PRODUCT PROBLEM

1. <b>Type of Report</b> ( <i>check all that apply</i> ) Adverse Event Product Problem ( <i>e.g., defects/malfunctions</i> )		2. <b>Outcome Attributed to Adverse Event</b> ( <i>check all that apply</i> ) Death – Date of death ( <i>01-JAN-1900</i> ): Life-threatening Hospitalization (initial or prolonged) Other Serious or Important Medical Events  Required Intervention to Prevent Permanent Impairment/Damage Disability or Permanent Damage Congenital Anomaly/Birth Defects	
3. <b>Date of Event</b> ( <i>01-JAN-1900</i> )	4. <b>Date of this Report</b> ( <i>01-JAN-1900</i> )		

**Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.**

\* Please see instructions

**5. Describe Event or Problem**

**6. Relevant Test/Laboratory Data**

**Date** (01-JAN-1900)

**Relevant Test/Laboratory Data**

**Date** (01-JAN-1900)

**Additional comments**

7. **Other Relevant History, Including Preexisting Medical Conditions** (e.g., allergies, pregnancy, tobacco product use, alcohol use, and liver/kidney problems, etc.)

### C. SUSPECT PRODUCTS

#### SUSPECT PRODUCT #1

**1. Name, Strength, Manufacturer/Compounder**

Product Name		Strength	Unit
NDC # or Unique ID	Manufacturer/Compounder Name		Lot #

**2. List Medical Product and Treatment Given at the Same Time of the Event and Date** (Do not include treatment for initial event)

<b>3. Dose or Amount</b>	<b>Frequency</b>	<b>Route</b>
Unit	Other Frequency	Other Route

**4. Treatment Dates/Therapy Dates** (give best estimate of length of treatment (start/stop) or date of dose reduction.)

Therapy started on (e.g., 01-Jan-1900)	Therapy stopped on (e.g., 01-Jan-1900)	Dose Reduced (e.g., 01-Jan-1900)	<b>OR</b>	Duration	Unit
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**5. Diagnosis for use (indication)** **6. Product Type (check all that apply)** **7. Expiration Date (e.g., 01-Jan-1900)**

<input type="checkbox"/> OTC <input type="checkbox"/> Generic <input type="checkbox"/> Compounded <input type="checkbox"/> Biosimilar		
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**8. Event Abated after use Stopped or Dose Reduced?** **9. Event Reappeared after Reintroduction?**

Yes      No      Doesn't apply	Yes      No      Doesn't apply
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**SUSPECT PRODUCT #2****1. Name, Strength, Manufacturer/Compounder**

Product Name		Strength	Unit
NDC # or Unique ID	Manufacturer/Compounder Name		Lot #

**2. List Medical Product and Treatment Given at the Same Time of the Event and Date** *(Do not include treatment for initial event)*

<b>3. Dose or Amount</b>	<b>Frequency</b>	<b>Route</b>
Unit	Other Frequency	Other Route

**4. Treatment Dates/Therapy Dates** *(give best estimate of length of treatment (start/stop) or date of dose reduction.)*

Therapy started on <i>(e.g., 01-Jan-1900)</i>	Therapy stopped on <i>(e.g., 01-Jan-1900)</i>	Dose Reduced <i>(e.g., 01-Jan-1900)</i>	<b>OR</b>	Duration	Unit
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<b>5. Diagnosis for use</b> <i>(indication)</i>	<b>6. Product Type</b> <i>(check all that apply)</i>	<b>7. Expiration Date</b> <i>(e.g., 01-Jan-1900)</i>
	OTC                      Generic Compounded            Biosimilar	

<b>8. Event Abated after use Stopped or Dose Reduced?</b> Yes      No      Doesn't apply	<b>9. Event Reappeared after Reintroduction?</b> Yes      No      Doesn't apply
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**D. SUSPECT MEDICAL DEVICE**

<b>1. Brand Name</b>	<b>2a. Common Device Name</b>	<b>2b. Procode</b>
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**3. Manufacturer Name, City and State**

<b>4. Model #</b>	<b>Lot #</b>	<b>Catalog #</b>
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<b>Expiration Date</b> <i>(01-JAN-1900)</i>	<b>Serial #</b>
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Unique Device Identifier (UDI) #																																				
<b>5. Operator of Device</b> Health Professional      Patient/Consumer Other		<b>6a. If Implanted, Give Date (01-JAN-1900)</b>	<b>6b. If Explanted, Give Date (01-JAN-1900)</b>																																	
<b>7a. Is this a single-use device that was reprocessed and reused on a patient?</b> Yes      No		<b>7b. If yes, enter the name and address of the reprocessor</b>																																		
<b>8. Was this device ever serviced by a third-party servicer?</b> Yes      No      Unknown		<b>9. Is this Device Available for Evaluation? (Do not send to FDA)</b> Yes      No Returned to manufacturer on (01-JAN-1900)																																		
<b>10. Concomitant Medical Products and Therapy Dates (Exclude treatment of event)</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%;">Product Name</th> <th style="width: 25%;">Therapy Start Date (01-JAN-1900)</th> <th style="width: 30%;">Therapy End Date (01-JAN-1900)</th> </tr> </thead> <tbody> <tr><td>1.</td><td></td><td></td></tr> <tr><td>2.</td><td></td><td></td></tr> <tr><td>3.</td><td></td><td></td></tr> <tr><td>4.</td><td></td><td></td></tr> <tr><td>5.</td><td></td><td></td></tr> <tr><td>6.</td><td></td><td></td></tr> <tr><td>7.</td><td></td><td></td></tr> <tr><td>8.</td><td></td><td></td></tr> <tr><td>9.</td><td></td><td></td></tr> <tr><td>10.</td><td></td><td></td></tr> </tbody> </table>				Product Name	Therapy Start Date (01-JAN-1900)	Therapy End Date (01-JAN-1900)	1.			2.			3.			4.			5.			6.			7.			8.			9.			10.		
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<b>2. Health Professional?</b> Yes      No		<b>3. Occupation (Select from list)</b>																																		
<b>4. Initial reporter also sent report to FDA</b> Yes      No      Unknown																																				

## F. FOR USE BY USER FACILITY/IMPORTER (Devices Only)

1. Check One User Facility      Importer		2. User Facility/Importer Report Number	
3. User Facility or Importer Name/Address		4. Contact Person	
5. Phone Number		6. Date User Facility or Importer Became Aware of Event (01-JAN-1900)	
7. Type of Report		8. Date of This Report (01-JAN-1900)	
9. Approximate Age of Device		10. Adverse Event Problem (Refer to coding manual)	
Health Effect – Clinical Code	Health Effect – Impact Code	Medical Device Problem Code	Component Code
11. Report Sent to FDA? (If Yes, enter date (01-JAN-1900)) Yes      No		12. Location Where Event Occurred Ambulatory Surgical Facility      Outpatient Treatment Facility      Other (Specify) Home      Outpatient Diagnostic Facility Hospital      Nursing Home	
13. Report Sent to Manufacturer? (If Yes, enter date (01-JAN-1900)) Yes No		14. Manufacturer Name/Address	

## G. ALL MANUFACTURERS

1. Contact Office (and Manufacturing Site for Devices) or Compounding Outsourcing Facility				
Name		Email Address		Phone Number
Address				
Compounding Outsourcing Facility 503B? Check box if applicable		Outsourcing Facility		
2. Report Source (check all that apply) Foreign      Literature      Health Professional      Company Representative Study      Consumer      Use Facility      Distributor/Importer      Other (Please list)				3. Date Received by Manufacturer (01-JAN-1900)
4. NDA #	ANDA #	IND #	BLA #	PMA/510(k) #
Check all that apply: Combination product      Pre-ANDA      Pre-1938      OTC      Compounded Product				
5. If IND/Pre-ANDA, Give Protocol #		6. Type of Report (Check all that apply) 5-day      15-day      Periodic      Follow-up # 7-day      30-day      Initial		
7. Adverse Event Term(s)			8. Manufacturer Report Number	

## H. DEVICE MANUFACTURERS ONLY

<b>1. Type of Reportable Event</b> <i>(check all that apply.)</i> Death                      Malfunction Serious Injury              Summary Report No. of events summarized		<b>2. If Follow-up, What Type?</b> Correction Additional Information Response to FDA Request Device Evaluation		<b>3. Device Evaluated by Manufacturer?</b> Yes              No	
<b>4. Device Manufacture Date</b> (01-JAN-1900)		<b>5. Labeled for Single Use?</b> Yes              No			
<b>6. Adverse Event Problem</b> <i>(Refer to coding manual)</i>					
Health Effect – Clinical Code		Health Effect – Impact Code		Medical Device Problem Code	
Component Code					
Type of Investigation		Investigation Findings		Investigation Conclusions	
<b>7. If Remedial Action Initiated, Check Type</b> Recall                      Relabeling                      Patient Monitoring Repair                      Notification                      Modification/Adjustment Replace                      Inspection                      Other:					<b>8. Usage of Device</b> Initial Use of Device Reuse Unknown
<b>9. If action reported to FDA under 21 USC 360i(g), list correction/ removal reporting number:</b>			<b>10. Related Report Number</b>		
<b>11. Additional Manufacturer Narrative</b>					

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