



# CLASS III MEDICAL DEVICE LICENCE AMENDMENT APPLICATION FORM

(disponible en français)

**1. NAME(S) OF DEVICE LICENCE(S) BEING AMENDED**

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**2. LICENCE NUMBER(S) TO BE AMENDED:** (provide the **latest valid** licence number(s))

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**3. MANUFACTURER INFORMATION** (as it appears on the label)

Contact Name and Title:		Company ID (if known):	
Company Name:			
Telephone:	Fax:	E-mail:	
Street:		Suite:	PO Box:
City:	Province/State:	Country:	Postal/Zip Code:

**4. REGULATORY CORRESPONDENT INFORMATION**     Same as Manufacturer     Other (specify below)

Contact Name and Title:		Company ID (if known):	
Company Name:			
Telephone:	Fax:	E-mail:	
Street:		Suite:	PO Box:
City:	Province/State:	Country:	Postal/Zip Code:

**5. INVOICING INFORMATION**     Same as Manufacturer     Same as Regulatory Correspondent     Other (specify below)

Contact Name and Title:		Company ID (if known):	
Company Name:			
Telephone:	Fax:	E-mail:	
Street:		Suite:	PO Box:
City:	Province/State:	Country:	Postal/Zip Code:

**6. QUALITY MANAGEMENT SYSTEM CERTIFICATE** (ensure that certificate is attached)

Quality Management System Certificate Number:	Name of Registrar:
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**7. ATTESTATIONS**

Specific to Part I, Section 32(3) of the <i>Medical Devices Regulations</i> relevant to the licensing of Class III medical devices, a senior officer shall submit an application to the Minister that contains the following attestation as applicable ( <b>check (✓) the relevant attestations</b> ):	
<input type="checkbox"/>	If the device contains a drug, I, <b>the Manufacturer</b> of this device, attest that the drug meets acceptable standards of safety, efficacy, and quality.



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**I, as a senior official of the manufacturer named in Item 3 of this application, hereby attest that I have direct knowledge of the items checked above and declare that these identified statements are true and that the information provided in this application and in any attached documentation is accurate and complete.**

**Where a person is named in Item 4 of this application, I hereby authorize that person to submit this application to the Minister on my behalf. I further authorize the Medical Devices Bureau to direct all correspondence relating to this application to the person named in Item 4 of this application. Please ensure that all information and documents set out in Section 32 of the *Medical Devices Regulations* that are relevant to the change has been enclosed.**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COMPLETE ITEMS 8 and 9 ONLY IF THEY HAVE CHANGED FROM THE PREVIOUS LICENCE**

**8. PLACE OF USE**

Is this device sold for home use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this device used at a point of care, such as a pharmacy, bedside, or healthcare professional's office? ( <i>In Vitro Diagnostic Devices [IVDD] ONLY</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this device an IVDD?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**9. MEDICAL DEVICES CONTAINING DRUGS**

**9.1 Non-IVD Devices Containing Drugs**

If the device contains a drug and is not an IVDD, indicate the Drug Identification Number (DIN) or the Natural Product Number (NPN) and complete the information listed below. If the drug does not have a DIN or NPN, please provide the Drug Establishment Licence (DEL) number of the company from where the drug is sourced.

Brand / Trade Name of Drug:	DIN/NPN:
Active Ingredient(s):	
Drug Manufacturer:	
DEL Number:	

**9.2 IVDD Test Kits containing Controlled Substances**

If this device is an IVDD test kit containing a substance listed in Schedule I, II, III, or IV of the Controlled Drugs and Substances Act, complete the section below.

Is this an IVDD Test Kit containing a controlled substance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Test Kit Number (T.K. Number):		

**Please note:** The manufacturer will need to contact the Office of Controlled Substances to obtain a T.K. Number if one has not yet been issued.

**10. REASON FOR AMENDMENT (✓ appropriate change)**

▶ A change to the classification of the device	<input type="checkbox"/>	From Class: _____ To Class: _____
▶ A change in the Manufacturer's name	<input type="checkbox"/>	Ensure that Item 1 is completed
▶ A change in the device licence name (that is [i.e.] previous device name no longer available for sale)	<input type="checkbox"/>	New device licence name: _____ (add attachment if more space is needed)
▶ A significant change in manufacturing process, facility of equipment	<input type="checkbox"/>	

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▶ A significant change in manufacturing quality control procedures	<input type="checkbox"/>	
▶ A significant change in design or performance specifications	<input type="checkbox"/>	
▶ A significant change in the materials	<input type="checkbox"/>	➤ Device contains $\geq 0.1\%$ w/w of Di (2-Ethyl hexyl) Pthalate [DEHP]* <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ Device is manufactured from materials <input type="checkbox"/> Yes <input type="checkbox"/> No containing or derived from bisphenol A (BPA)*
▶ A significant change in the labelling of the device	<input type="checkbox"/>	
▶ Any change which could affect the safety and effectiveness of the device	<input type="checkbox"/>	
▶ An addition, deletion or change in device components or associated model, part or catalogue numbers	<input type="checkbox"/>	Complete below

\* Please consult the document "Guidance for Industry: How to Complete the Application for a New Medical Device Licence", which is available on the website, for the definition of DEHP and BPA.











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**CURRENCY:** The dollar (\$) amounts on this form refer to Canadian dollars. All payments must be made in Canadian Dollars.

## 14. REVIEW FEES FOR LICENCE AMENDMENT APPLICATIONS

The fees for the examination of licence amendment applications are shown below. For further information on the applicable fees, refer to the *Guidance Document - Fees for the Review of Medical Device Licence Applications*.

Category	Fee
Class III licence amendment application – a significant change that relates to manufacturing	\$1,270
Class III licence amendment application – a significant change or change that would affect the Class of the device that is not related to manufacturing	\$4,730

## 15. FEE FOR LICENCE APPLICATION

Enter the appropriate fee in box 15.1	<b>15.1</b>
The payment <b>must be included</b> in the licence application.	

**16. DEFERRED PAYMENT:** If a manufacturer has not completed its first fiscal year on the day that the medical device licence application is submitted, the manufacturer will be granted a one-year deferral of payment from the day the application is submitted. The deferral will also be applicable to fees associated with a licence amendment for the medical device that become payable within that one-year period. **In order to qualify for the deferral period, a statement signed by the individual responsible for the manufacturer’s financial affairs specifying the commencement date of the fiscal year must be submitted with the application.** At the end of the one-year period, the manufacturer must pay all of the applicable fees.

Please indicate if the applicant is applying for a deferred payment:  A deferred payment is requested



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## 17. FEE REMISSION

### 17.1 Eligibility for Remission and Necessary Documentation

When applying for a fee remission, **the necessary documentation must accompany the licence application. Failing to do so will result in the rejection of the fee remission application.**

In order to be eligible for a remission, the anticipated gross revenue must be less than \$100,000, and the full fee, as indicated in box 15.1 above, must be greater than 2.5% of the anticipated gross revenue from sales of the medical device in Canada during the fee verification period. For the purposes of fee remission, the **fee verification period** is the period beginning on the date that the medical device is first offered for sale in Canada and ending two years after that date.

#### Necessary Documentation:

(1) The applicant must provide a statement signed by the individual responsible for the applicant's financial affairs indicating that the anticipated gross revenue during the fee verification period is \$100,000 or less, and certifying that the fee indicated in box 15.1 above is more than an amount equal to 2.5% of the anticipated gross revenue.

(2) The applicant must present information to establish that the applicable fee is greater than 2.5% of the anticipated gross revenue from sales of the medical device in Canada during the fee verification period. The information should provide an accurate measure of the current market situation for the proposed product. Information to support the anticipated revenue should include as a minimum:

- marketing plan/product plan for the medical device;
- sales history prior to product upgrades or sales history of similar products;
- estimated market share (that is [i.e.], product's market potential compared to the total market for similar products in Canada);
- average sale price and demand; and
- comparison to similar products on the Canadian market or other similar markets (for example [e.g.], United States, European Union, etc.)

The calculation for the applicable fee following remission is as follows:

*Anticipated gross revenue for this medical device during the fee verification period* \_\_\_\_\_ \$CAN (A) (if amount is less than \$100,000)

*2.5% of amount (A) = \$ \_\_\_\_\_ = Applicable fee*

The payment must be included in the licence application.

**Refer to the Guidance Document - Fees for the Review of Medical Device Licence Applications for further information on fee remissions.**

### 17.2 Application for Fee Remission

Enter the anticipated gross revenue for this medical device during the fee verification period in box 17.1	<b>17.1</b>
Enter 2.5% of amount in box 17.1 in box 17.2	<b>17.2</b>
Enter \$50 processing fee in box 17.3	<b>17.3</b>
<b>Total fee to be paid:</b> Enter the sum of boxes 17.2 and 17.3 in box 17.4	<b>17.4</b>

## 18. METHOD OF PAYMENT (check method)

<input type="checkbox"/> MasterCard / Visa / American Express (AMEX)	<input type="checkbox"/> Cheque	<input type="checkbox"/> Money order	<input type="checkbox"/> International bank draft
<input type="checkbox"/> Payment using existing credit	<input type="checkbox"/> Wire		



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## 19. PAYMENT BY CREDIT CARD

Company's Full (Legal) Name:		Application Name (e.g., product name, file name):	
Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX	Credit Card Number (full number):		
Credit Card Valid Date:	Credit Card Expiry Date:		
Cardholder's Name and Address:			
Street:			
City:	Province/State:	Country:	Postal/Zip Code:
Cardholder's Telephone Number (including country and area codes):			

## 20. PAYMENT BY CHEQUE / MONEY ORDER / INTERNATIONAL BANK DRAFT

Cheques, money orders or international bank drafts must be made payable to the "Receiver General for Canada". All cheques are to be in Canadian funds **drawn from a Canadian Bank**. Cheques drawn from non-Canadian banks **MUST** be issued in coordination with a referenced Canadian bank (i.e., referenced on the cheque), otherwise they are **NOT ACCEPTED**.

## 21. PAYMENT BY WIRE

Company's Full (Legal) Name:	Application Name (e.g., product name, file name):
Name of Originator Bank:	Date Funds Wired:
Amount of Funds Wired (Canadian \$):	<input type="checkbox"/> Transaction Receipt Included (must attach)
Wire payments of fees will be accepted only when wired to:	
<ul style="list-style-type: none"> <li>The Bank of Nova Scotia, Toronto Business Service Centre, 40 King St., West, Toronto, Ontario, Canada, M5H 1H1</li> <li>SWIFT code: NOSCCATT</li> <li>Institution number: 002</li> <li>Transit number: 47696</li> <li>Beneficiary Name: HEALTH CANADA – CFOB (Department Name)</li> <li>Account number: 476961242210*(<i>please ensure 12 digit #</i>)</li> <li>Description Field: Authorization Number: 022-22879 (<i>please ensure 8 digit # is provided</i>)</li> </ul>	
Please remit payments in <b>CANADIAN FUNDS</b> only. All other currencies will be <b>rejected</b> .	
Note that the wire standards used in Canada offer 4 lines of description fields, each with a maximum of 35 characters. For customer identification and ease of reconciliation, it is recommended that you also request that your customers input other pertinent information in these fields, e.g. invoice number, payment period, contact information. Please be aware that wires are often passed through intermediary financial institutions, especially in the case of wires originated outside of Canada, and it is possible that details within the description fields might be truncated.	
Note that <b>your bank may deduct a fee for this service which may then result in an unexpected balance owing. You must ensure that all service charges are covered by your payment.</b> For further information on wire payment, contact Accounts Receivable at tel. 1-800-815-0506 or (613) 957-1052 or via e-mail at AR-CR@HC-SC.GC.CA.	

## 22. PAYMENT USING EXISTING CREDIT (attach to the application a copy of the most recent statement)

Account # Containing Credit:	Account Owner's Name:	Existing Credit Amount:
Total Device Licence Application Fee:		\$
Portion of Device Licence Application Fee to be Paid for by Credit:		\$
Remainder of Fee to be Paid by Another Method (check one of the methods above, see Items 18 to 21):		\$

**CREDITS:** Overpayment of fees will be automatically credited to account. **Refunds** of credit balances must be requested in writing by the account owner and must be on company letterhead. Address: Health Canada, Accounts Receivable, P/L 3203B, Room B350, Ottawa, Ontario, K1A 0K9, Canada.



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## LICENCE APPLICATION DISCLOSURE REQUEST

As you are aware, Health Canada is striving to add transparency to the medical device review process. One area we would like to address is the requests from interested parties regarding whether or not a licence application has been received by the Medical Devices Bureau (MDB).

The purpose of this form is to request your signed authorization - in advance - if we receive such a request, to disclose the date on which a licence application has been received by the MDB. No other information would be supplied.

Please indicate your consent by completing this form and sending it with your application for a new medical device licence, or any time after a licence has been granted.

### Disclosure Statement:

In the case where the Medical Devices Bureau (MDB) has received requests concerning the status of the new licence application, amendment application, or fax-back application for (enter device name)

from interested parties,

- this certifies that (*enter the manufacturer's name*) \_\_\_\_\_ has **no objection** to the disclosure to the requester, by the MDB, of the date when an application for the device entered above, has been received by the MDB
- this certifies that (*enter the manufacturer's name*) \_\_\_\_\_ **objects** to the disclosure to the requester, by the MDB, of the date when an application for the device entered above, has been received by the MDB

In accordance with the *Access to Information Act*, confidential, third party information will not be disclosed without your expressed consent.

\_\_\_\_\_  
Manufacturer's authorized signing official

Application forms should be sent to:

Device Licensing Services Division  
Medical Devices Bureau  
Therapeutic Products Directorate  
Health Canada  
2934 Baseline Road  
Address Locator: 3403A  
OTTAWA, Ontario K1A 0K9

Phone: (613) 957-7285

Fax: (613) 957-6345

E-mail: [device\\_licensing@hc-sc.gc.ca](mailto:device_licensing@hc-sc.gc.ca)