# Skráningarform Dreifingaraðila

**(REGISTRATION FORM FOR DISTRIBUTORS)**

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| Dreifingaraðili lækningatækis:  (Distributor) | | Kennitala:  (ID number) | Heimilisfang:  (Address) | | | | Póstnúmer:  (Postnumber) | |
|  | |  |  | | | |  | |
| Tengiliður:  (Contact person) | | | Netfang:  (e-mail address) | | | | Sími:  (Telephone number) | |
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| Umboð  (Brand name) | | | Tengiliður:  (Contact person) | | | | | |
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|  | Undirskrift tilkynnanda  (Signature) | | | |  | Dagsetning  (Date) | |  |