



This form must be full filled (in block letters), signed and sent with a duplex copy of a valid identity document to the fax number + 39 06-5492 2015

The undersigned,

Name			
Surname			
Place of birth			
Date of birth			
<i>Residence address</i>			
Address			
City/Country		ZIP Code	
User Name			
<i>Other information</i>			
Telephone number		Mobile phone number	
E-Mail address			

requests the reset password to access the Agenzia Italiana del Farmaco's payment system.

*I authorize the processing of personal data in accordance with the actual laws*

Signed \_\_\_\_\_

*Within 48 hours, password will be reset at the date of birth by the following format: ddmmyyyy.*