Reset Form

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. **Patient Identifier** *(In confidence)*

2. Age
☐ Year(s) ☐ Week(s)
☐ Month(s) ☐ Day(s)

or Date of Birth *(e.g., 01-Jan-1900)*

3a. **Sex:** Enter the patient's sex at birth *(the sex that a person has or was assigned to at birth).*
☐ Male ☐ Undifferentiated
☐ Female ☐ Decline to answer

3b. **Gender:** Enter the patient's current gender *(how the patient thinks of themself).*
☐ Cisgender man/boy (gender corresponds with birth sex)
☐ Cisgender woman/girl (gender corresponds with birth sex)
☐ Transgender man/trans man/ female-to-male (FTM)
☐ Transgender woman/trans woman/ male-to-female (MTF)
☐ Other gender category; please specify:
☐ Decline to answer

4. **Weight**
☐ lb
☐ kg

5. **Ethnicity** *(Check one)*
☐ Hispanic/Latino
☐ Not Hispanic/Latino

6. **Race** *(check all that apply)*
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/ Other Pacific Islander
☐ White

B. ADVERSE EVENT OR PRODUCT PROBLEM

1. **Type of Report** *(check all that apply)*
☐ Adverse Event
☐ Product Problem *(e.g., defects/malfunctions)*

2. **Outcome Attributed to Adverse Event** *(check all that apply)*
☐ Death – Date of death *(01-JAN-1900):*
☐ 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. **Date of Event** *(01-JAN-1900)*

4. **Date of this Report** *(01-JAN-1900)*

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

(continued on next page)

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)*

3. **Dose or Amount**	**Frequency**	**Route**
	--	--
Unit	**Other Frequency**	**Other Route**
--		

4. **Treament 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)* **OR**	Duration	Unit
				--

5. **Diagnosis for use** *(indication)*	6. **Product Type** *(check all that apply)*	7. **Expiration Date** *(e.g., 01-Jan-1900)*
	☐ OTC ☐ Generic ☐ Compounded ☐ Biosimilar	

8. **Event Abated after use Stopped or Dose Reduced?**	9. **Event Reappeared after Reintroduction?**
☐ Yes ☐ No ☐ Doesn't apply	☐ Yes ☐ No ☐ Doesn't apply

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)*

3. **Dose or Amount**	**Frequency**	**Route**
Unit --	**Other Frequency**	**Other Route**

4. **Treament 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)* **OR**	Duration	Unit
				--

5. **Diagnosis for use** *(indication)*	6. **Product Type** *(check all that apply)*	7. **Expiration Date** *(e.g., 01-Jan-1900)*
	☐ OTC ☐ Generic ☐ Compounded ☐ Biosimilar	

8. **Event Abated after use Stopped or Dose Reduced?**	9. **Event Reappeared after Reintroduction?**
☐ Yes ☐ No ☐ Doesn't apply	☐ Yes ☐ No ☐ Doesn't apply

D. SUSPECT MEDICAL DEVICE

1. **Brand Name**	2a. **Common Device Name**	2b. **Procode**

3. **Manufacurer Name, City and State**

4. **Model #**	**Lot #**	**Catalog #**

Expiration Date *(01-JAN-1900)*	**Serial #**

Unique Device Identifier *(UDI)* **#**

5. **Operator of Device** ☐ Health Professional ☐ Patient/Consumer ☐ Other	6a. **If Implanted, Give Date** *(01-JAN-1900)*	6b. **If Explanted, Give Date** *(01-JAN-1900)*
7a. **Is this a single-use device that was reprocessed and reused on a patient?** ☐ Yes ☐ No	7b. **If yes, enter the name and address of the reprocessor**	
8. **Was this device ever serviced by a third-party servicer?** ☐ Yes ☐ No ☐ Unknown	9. **Is this Device Available for Evaluation?** *(Do not send to FDA)* ☐ Yes ☐ No ☐ Returned to manufacturer on *(01-JAN-1900)*	

10. **Concomitant Medical Products and Therapy Dates** *(Exclude treatment of event)*

Product Name	Therapy Start Date *(01-JAN-1900)*	Therapy End Date *(01-JAN-1900)*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

E. INITIAL REPORTER

1. **Name and Address**

Last Name	First Name		
Address			
City	State/Province/Region	ZIP/Postal Code	Country --
Phone #	Email		

2. **Health Professional?** ☐ Yes ☐ No	3. **Occupation** *(Select from list)* --	4. *Initial reporter also sent report to FDA* ☐ 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 Faciltiy ☐ 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

1. **Type of Reportable Event** *(check all that apply.)*	2. **If Follow-up, What Type?**	3. **Device Evaluated by Manufacturer?**
☐ Death ☐ Malfunction ☐ Serious Injury ☐ Summary Report No. of events summarized	☐ Correction ☐ Additional Information ☐ Response to FDA Request ☐ Device Evaluation	☐ Yes ☐ No

4. **Device Manufacture Date** *(01-JAN-1900)*	5. **Labeled for Single Use?**
	☐ Yes ☐ No

6. **Adverse Event Problem** *(Refer to coding manual)*

Health Effect – Clinical Code	Health Effect – Impact Code	Medical Device Problem Code	Component Code

Type of Investigation	Investigation Findings	Investigation Conclusions

7. **If Remedial Action Initiated, Check Type**			8. **Usage of Device**
☐ Recall	☐ Relabeling	☐ Patient Monitoring	☐ Initial Use of Device
☐ Repair	☐ Notification	☐ Modification/Adjustment	☐ Reuse
☐ Replace	☐ Inspection	☐ Other:	☐ Unknown

9. **If action reported to FDA under 21 USC 360i(g), list correction/ removal reporting number:**	10. **Related Report Number**

11. **Additional Manufacturer Narrative**

PRIVACY ACT STATEMENT

Authority: The information collected in this form is provided to comply with the Privacy Act of 1974 (P.L. 93-579) for individuals seeking non-employee student, post-graduate or senior scientist training opportunities from the Food and Drug Administration. Purpose and Uses: All information collected in this form is required to begin the Traineeship. Completed forms are used by the Staff to meet program selection and on-boarding requirements. Information is also shared with the FDA personnel authorized to administer the program. Effects of nondisclosure: Disclosure of the information is voluntary; however, collection of this information is necessary to continue with the FDA.

PRA Info

This section applies only to requirements of the Paperwork Reduction Act of 1995.

DO NOT SEND YOUR COMPLETED FORM TO THE PRA STAFF EMAIL ADDRESS BELOW.

The burden time for this collection of information is estimated to average 15 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden, to:

Department of Health and Human Services
Food and Drug Administration
Office of Operations
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."