	FO-QUA-017-2	FORMULAIRE
	Undesirable Effect(s) Declaration	Version : 1.1
		Rédigé par : Dana Battipaglia
		Date de validité : 01.02.2025
		Date de révision : 26.05.2025

I- Consumer Information

N° RC:
Filled by MARGYS.COM

<u>Name (at least initials):</u>	
<u>Birth date or Age:</u>	
<u>Gender:</u>	<input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> Does not want to answer
<u>Phone:</u>	
<u>E-mail:</u>	
<u>Particular Conditions:</u>	<input type="checkbox"/> Known allergies. If yes, which ones? <input type="checkbox"/> Pregnant <input type="checkbox"/> Breastfeeding <input type="checkbox"/> None
<u>Skin types</u>	<input type="checkbox"/> Normal <input type="checkbox"/> Oily <input type="checkbox"/> Combination <input type="checkbox"/> Sensitive <input type="checkbox"/> Dry

II- Product Information


<u>Product Name:</u>	
<u>Product Reference (Mxxxxx):</u>	
<u>Batch Number</u> : <i>(under the bottle/jar or on the tube's seal)</i>	
<u>Product opening date:</u>	
<u>Point of purchase:</u>	<input type="checkbox"/> Shop. If yes, specify: <input type="checkbox"/> Website
<u>Possible associated products in the last month:</u> <i>(other cosmetic products, medications, peeling, injections, lifting treatment etc.)</i> <i>Please specify the brand names.</i>	

III- Undesirable Effect description

Symptoms apparition Date:

How long after use did the adverse effect appear?

days/weeks/months

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Observed symptoms: *Please, check all that apply and provide photos and videos*

- Redness
- Irritation
- Itching
- Swelling
- Skin rashes
- Burn
- Warm sensation
- Pain
- Other (specify):

Location of symptoms

- Face
- Eye contour
- Body
- Other (specify):

Symptoms on the applied area

- Yes
- No, symptoms also distant from the application:

Severity of the adverse effect

- Mild (temporary symptoms). If yes, how long did it take to disappear and what did you do?

- Moderate (requires medical treatment or medical attention) : if yes, which one ? *Please, provide the information given by doctor*

- Severe (emergency medical attention required). If yes, please, give us details:
Please, provide the information given by doctor

Additional comments

Consent

I consent to my information being used for safety investigations of cosmetic products.
I agree to be contacted for further information regarding this report.

Signature: _____
(First and Last Name, or Electronic Signature)

Date: __ / __ / ____

Please, send this to qualitycontrol@margys.com or dana.battipaglia@margys.com.