****FORMULARIO C1**

**MODELO DE CONSOLIDADO DE PEDIDO TRIMESTRAL FORMULARIO CPT**

***CONSOLIDADO DE PEDIDO TRIMESTRAL (CPT)***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Servicio Departamental de Salud:** |  |  |  |  |  |  |  |  |  | **Municipio:** |  |  |  |  |  |  |  |  |  |  |  |  | **Establecimiento:** |  |  |  |  |  |  |  |  |  |
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|  |  | **Responsable:** |  |  |  |  |  |  |  |  |  | **Coordinación de Red:** |  |  |  |  |  |  |  |  |  |  | **Nivel Máximo:** |  | **meses** |  |  |  |  |  |  |  |
|  |  | **Periodo de:** |  |  |  |  |  | **a:** |  |  |  | **Reporte:** |  |  |  |  |  |  |  |  |  |  |  |  | **Nivel Mínimo:** |  | **meses** |  |  |  |  |  |  |  |
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|  |  |  |  | **A** |  |  |  |  |  |  |  |  |  |  | **B** |  |  |  |  |  |  |  |  |  | **C** |  |  | **D** |  |  |  |  |  | **E** |  |
|  |  | **Forma F.** | **Concentración** |  | **SALDO FINAL DEL PERIODO** |  |  |  | **CONSUMO PROMEDIO MENSUAL (CPM) CPM-S + CPM-P + CPM-V** |  |  |  | **M.E.D.** |  | **CANTIDAD MÁXIMA** |  |  | **CANTIDAD A SOLICITAR** |  |
| **Código** | **Nombre Genérico** |  |  |  |  | **3er. Mes del trimestre** |  |  | **S (1+2+3)/n\*** |  |  |  | **P (1+2+3)/n\*** |  | **V** | **(1+2+3)/n\*** |  |  |  | **A/B** |  | **B x Nivel** | **Máximo** |  |  |  |  | **D** | **- A** |  |  |
|  |  | **Presentación** | **Unidad de M.** | **S** |  | **P** | **V** | **TOTAL** | **IMM** | **IMM** | **IMM** | **CPM-S** |  | **IMM** | **IMM** | **IMM** | **CPM-P** | **IMM** |  | **IMM** |  | **IMM** | **CPM-V** | **CPM** |  | **S** | **P** | **V** | **TOTAL** | **S** |  | **P** |  | **V** |  | **TOTAL** |
|  |  |  |  |  |  |  |  | **S+P+V** | **1** | **2** | **3** |  |  | **1** | **2** | **3** |  | **1** |  | **2** |  | **3** |  |  |  |  |  |  | **S+P+V** |  |  |  |  |  |  | **S+P+V** |
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|  | **Observaciones:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Firma:** |  |  |  |  |  |  |  |  |  |
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|  |  | **Puntos de Información registrados:** |  |  |  |  | **Puntos de Información reportados:** |  |  |  |  |  | **Puntos de Información consolidados:** |  |  |  |  |  |  |  |  |  |  |  |
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| **n\*:** número de IMM con consumo mayor a 0 |  |  |  |  |  | **Elaborado por:** |  |  |  |  |  |  |  |  |  |  | **Fecha:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**FORMULARIO C2**

**FORMULARIO ÚNICO DE COMPRAS – FUC (FORMULARIO SNUS – 05)**



**PÁGINA\_\_\_\_DE\_\_\_\_\_ FORMULARIO ÚNICO DE COMPRAS DIRECTA**

 **DE MEDICAMENTOS Y DISPOSITIVOS MÉDICOS**

**(FUC)**

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| **ENTIDAD****SOLICITANTE** |

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| **GOBIERNO AUTÓNOMO MUNICIPAL**  |  |
| **GOBIERNO AUTÓNOMO DEPARTAMENTAL**  |  |
| **ENTE GESTOR DEL SSCP** |  |
| **INSTITUCIÓN PÚBLICA NIVEL CENTRAL****FECHA DE SOLCITUD** |  |
| **MINISTERIO DE DEFENSA PARA LAS FFAA** |  |

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Solicitante

Proveedor Seleccionado

Nombre

Nombre o Razón Social

Representante Legal

Domicilio Legal

Domicilio Legal

Máxima Autoridad Ejecutiva

Representante Legal

Responsable principal (solicitud)

Cargo

**ITEM SOLICITADOS SEGÚN MODALIDAD DE COMPRA DIRECTA**

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| **N°** | **CODIGO** | **MEDICAMENTO / DISPOSITIVO MÉDICO**(SEGÚN LINAME Y LISTADO DE SISPOSITIVOS MÉDICOS ESENCIALES) | **FORMA FARMACEUTICA** | **CONCENTRACIÓN** | **CANTIDAD SOLICITADA** | **PRECIO UNITARIO (Bs)** | **PRECIO TOTAL (Bs)** | **PLAZO DE ENTREGA** |
| **1** |  |  |  |  |  |  |  |  |  |  |
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| **20** |  |  |  |  |  |  |  |  |  |  |
| **21** |  |  |  |  |  |  |  |  |  |  |

Lugar de entrega (Dirección Completa):

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 FIRMA Y SELLO FIRMA Y SELLO FIRMA Y SELLO

 RESPONSABLE DE LA SOLICITUD MÁXIMA AUTORIDAD EJECUTIVA REPRESENTANTE LEGAL PROVEEDOR

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 **FORMULARIO C3**

**FORMULARIO ÚNICO DE REMISIÓN Y RECEPCIÓN DE MEDICAMENTOS Y DISPOSITIVOS MÉDICOS (FURR)**

Receptor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Empresa Proveedora:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Domicilio:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dirección:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Representante de la Empresa:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Establecimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Almacén:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Número de factura:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Orden: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fecha de recepción:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATOS DEL MEDICAMENTO**

Nombre genérico:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre comercial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forma farmacéutica: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concentración: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Presentación:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laboratorio:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Origen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nº de Registro Sanitario en Bolivia:\_\_\_\_\_\_\_\_\_\_\_\_\_ Otros: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Cantidad Recibida** | **Número de empaques** | **Número(s) de lote** | **Fecha de vencimiento** | **Vida útil (a la fecha de entrega)** | **Nº de Certificado de Análisis** |
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Examen Visual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Observaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

En conformidad:

Entidad Receptora: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Empresa Proveedora:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dirección: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nombre:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Programa:\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Firma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C.I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma(s) (Comisión de recepción): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C.I.(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma(s) (Comisión de recepción): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C.I.(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_, \_\_\_\_ de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ de 200\_\_

**FORMULARIO C4**

**FORMULARIO DE REMISIÓN Y RECEPCIÓN DE DISPOSITIVOS MÉDICOS –**

**EQUIPOS BIOMÉDICOS**

***(Para ser llenado cuando se realice la remisión y recepción de los dispositivos médicos- equipos biomédicos)***

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| **CUCE** | **:** |  |  |  | - |  |  |  |  | - |  |  | - |  |  |  |  |  |  | - |  | - |  |  |
|  |  |  | **::** |
| **institución** | **:** |  |  |  |
|  |  |  |  |
| **Domicilio** | **:** |  |  |  |
|  |  |  |  |
| **Representante de la Institución** | **:** |  |  |  |
|  |  |  |  |
| **Empresa Proveedora** | **:** |  |  |  |
|  |  |  |  |
| **Domicilio**  | **:** |  |  |  |
|  |  |  |  |
| **Representante de la Empresa** | **:** |  |  |  |
|  |  |  |  |
| **Fecha de recepción** | **:** |  |  |  |
|  |  |  |  |
| **Domicilio de recepción** | **:** |  |  |  |
|  |  |  |  |
| **Número de Factura** | **:** |  |  |  |
|  |  |  |  |
| **Almacén** | **:** |  |  |  |
|  |  |  |  |
| **Departamento** | **:** |  |  |  |
|  |  |  |  |
| **Orden** | **:** |  |  |  |
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| **DATOS DEL DISPOSITIVO MÉDICO – EQUIPO BIOMÉDICO** |
|  |  |  | **::** |
| **Código** | **:** |  |  |  |
|  |  |  |  |
| **Nombre Genérico** | **:** |  |  |  |
|  |  |  |  |
| **Nombre del producto (nombre comercial)** | **:** |  |  |  |
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|  |  |  |  |
| **Fabricante** | **:** |  |  |  |
|  |  |  |  |
| **País de origen** | **:** |  |  |  |
|  |  |  |  |
| **Nº Registro Sanitario en Bolivia o Nº Certificado de Comercialización****(Para el caso de equipos biomédicos).** | **:** |  |  |  |
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| **Presentación de Identificadores** | **:** |  |  |  |
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| **Cantidad Recibida** | **Número de empaques** | **Número(s) de lote/serie** | **Fecha de expiración o vencimiento** | **Periodo de vida útil (a la fecha de entrega)** | **Nº de Certificado de Análisis/Informe de Pruebas** |
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| **Examen Visual** | **:** |  |  |  |
| **Provisión de Información técnica-científica en idioma español** | **:** |  | Manual de operación | Manual de servicio | Manual de instalación | Manual departes | Instrucciones de uso |  |
|  |  |  |  |  |  |
|  |  |  |  |
| **Observaciones** | **:** |  |  |  |
|  |  |  |  |
| **Muestreo** | **:** |  | ***[Sí o No]*** |  |
|  |  |  |  |
| **Nº de Formulario de Muestreo** | **:** |  |  |  |
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| **CARTA DE COMPROMISO DE CAMBIO (Cuando corresponda)**(\*) Si la entrega incluye productos que requieren la presentación de carta de compromiso de cambio, indicar la referencia de la carta correspondiente, debiendo firmar como confirmación de la misma el representante de la empresa la siguiente aclaración |
|  |  |  | **::** |
| **Nº de Cite de la Carta** | **:** |  |  |  |
|  |  |  |  |
|  |  |
|  | **En conformidad** |  |
|  | **En conformidad por la Institución** | **Por la empresa** |  |
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