

Attachment

Reporting of personal information breach incident		
Name of medical devices wholesaler or retailer :	Reporting time: yyyy/mm/dd/hh/mm	
	Reporter:	(Signature or seal) Title:
	Telephone:	
Reporting to :	E-mail:	
	Address:	
The time of occurrence of the incident		
Type of incident	<input type="checkbox"/> theft <input type="checkbox"/> leakage <input type="checkbox"/> alteration <input type="checkbox"/> damage <input type="checkbox"/> loss <input type="checkbox"/> other	Total number of personal data breach (approx.) _____
		<input type="checkbox"/> General personal data _____ <input type="checkbox"/> Special personal data _____
Cause for the incident and description of the incident		
Damage		
Potential consequences of personal data breach		
Corresponding measures to be adopted.		
Time and method to inform the information owner		
Have you notify the information owner within 72 hours after discovering the breach?	<input type="checkbox"/> Yes <input type="checkbox"/> No, why:	