K.S. KIM INTERNATIONAL

Doctor Registration Form

1) I acknowledge that I have all the information packages in relation to the Lenalidomide S.K. Risk Management Program, which include:
   - ✓ Healthcare Professional Information Booklet,
   - ✓ Patient's Information Booklet,
   - ✓ Doctor's Registration Form,
   - ✓ Responsible Pharmacist/Pharmacy Registration form,
   - ✓ Patient Registration form,
   - ✓ Monthly Pregnancy Test form,
   - ✓ Pregnancy Report.

2) I have received the Healthcare Professional Information booklet and I fully understand its contents.

3) I have read and understand the principles of Lenalidomide S.K. Risk Management Program and I will work to prevent teratogenic risk in accordance with the Ministry of Health requirements.

4) I will provide the patient with the "Patient Information Booklet", explain the program and ensure that they understand the contents and their responsibility.

5) I have read "Storage of Personal Information" relating to the administration of the drug Lenalidomide S.K. I also agree that the personal information, as set out in this form, will be stored in a database managed by the registration owner, K.S. Kim International Ltd. in accordance with the Privacy Protection Law.

6) I will send to KS Kim, the signed declaration & registration forms for both physician and patient.

Name: _____

Registration Number: _____

Name of Healthcare Institution & City:

_____,_____

Contact Number: Email Address:

_____ _____

Signature & Stamp: Date:

_____ ____/_____/_____(DD/MM/YYYY)