DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

User Fee Payment Refund Request

Form Approved: OMB No. 0910-0805
Expiration Date: March 31, 2028
See PRA Statement on page 4.

Section A: Organization Information

1. Date of Request *(mm/dd/yyyy)*

2. Organization Name

3. Organization Address

Address 1 *(Street address. No P.O. Boxes allowed)*

Address 2 *(Apartment, suite, unit, building, floor, etc.)*

City | State/Province/Region

Country | ZIP or Postal Code

4. Type of Vendor *(Select applicable)*

☐ U.S. vendor ☐ Foreign vendor

5. TIN/EIN *(Nine-digit number required for **all** U.S. vendors.) Without this entry, refund cannot be processed.*

6. DUNS *(Nine-digit number required for **all** foreign vendors. See instructions for additional information.) Without this entry, refund cannot be processed.*

Section B: Contact Information

7. Contact Name

8. Contact Title/Position

9. Contact Phone Number *(Include area code)*

10. Contact Email Address

Section C: Payment Information

11. Payment Amount

12. Payment Reference Number

13. PIN or Invoice Number

14. Refund Amount

15. Is this a FURLS refund request? *(See instructions for more information.)* ☐ Yes ☐ No *(Proceed to field 16)*

(a) FURLS Request Type

☐ Used PIN ☐ Unused PIN *(Proceed to field 16)*

(b) Registration or Owner/Operator Number

(c) Why did your facility originally pay the fee?

(d) Why do you believe your facility is not required to pay the fee?

(e) List all activities performed at your facility

(Section C continued, next page)

Section C: Payment Information *(Continued)*

15. Is this a FURLS refund request? *(Continued)*

(f) List all products manufactured at your facility

16. Reason for Request *(Please explain)*

17. **ACKNOWLEDGEMENT: By signing this document I acknowledge that I am the official listed on this form, authorized to execute this request on behalf of my organization. Any questions regarding this request can be directed to me via the contact information provided.**

18. Signature	Date of Signature *(mm/dd/yyyy)*
To enable the signature field, please fill out all prior required fields. For a list of required fields which have not yet been filled out, please click here.	

Section D: FDA Acknowledgement

19. FDA Received Date *(mm/dd/yyyy)*	20. Center Decision ☐ Approved ☐ Denied
21. If Denied, State Reason	
22. Decision Date *(mm/dd/yyyy)*	23. Center Contact Name

OFM Use Only

24. Request Executed? ☐ Yes ☐ No	25. If No, State Reason
26. Final Action ☐ Completed – Refunded ☐ Completed – Not Refunded	27. Date of Final Action *(mm/dd/yyyy)*
28. OFM Contact Name	

Instructions for Completing User Fee Payment Refund Request – Form FDA 3913

Form FDA 3913 is to be completed online at http://www.fda.gov/forindustry/userfees/default.htm and is to be used when requesting the transfer of user fee payments received by the FDA. If you need assistance in completing this form contact the User Fee Helpdesk via phone at (301) 796-7200 or email userfees@fda.gov.

Section A: Payment Information

1. **Date of Request:** Enter calendar date the form is being completed.
2. **Organization Name:** This is name of the organization submitting the request.
3. **Organization Address:** Enter the following elements of the organization's address.

Address 1 – Enter organization's physical street address where the refund is to be sent. *No P.O. Boxes are allowed*.

Address 2 – As needed, enter apartment, suite, unit, building, floor, etc.

City – Enter the city where organization is located.

State/Province/Region – Enter the state, province or region where organization is located.

Country – Enter country where organization is located.

ZIP or Postal Code – Enter zip code or postal code of the organization's location.

4. **Type of Vendor:** Select the appropriate box to indicate whether the organization is a U.S. or foreign vendor.
5. **TIN/EIN:** *(U.S. vendor only)* Enter organization's nine-digit federal Taxpayer Identification Number (TIN) or Employer Identification Number (EIN). *Without this entry, the refund request cannot be processed*.
6. ***DUNS:*** *(Foreign vendor only)* Enter organization's nine-digit Dun & Bradstreet Data Universal Numbering System (DUNS) number. If you do not know your DUNS number or need to request one, visit *www.dnb.com* or call (800) 234-3867. *Without this entry the refund cannot be processed*.

Section B: Contact Information

7. **Contact Name:** Enter the name of the person requesting the refund.
8. **Contact Title/Position:** Enter the position/title of the person requesting the refund.
9. **Contact Phone Number:** Enter the phone number of the person requesting the refund.
10. **Contact Email Address:** Enter the email address of the person requesting the refund.

Section C: Payment Information

11. **Payment Amount:** Enter the amount (in U.S. Dollars) of the original payment issued to the FDA.
12. **Payment Reference Number:** If payment was remitted via check, money order or bank draft, enter the check or money order number; if made electronically via Automated Clearing House (ACH) or credit card, enter the confirmation number; if made via wire transfer, enter the trace or Input Message Accountability Data (IMAD) number.
13. **PIN or Invoice Number:** Enter the Payment Identification Number (PIN) or invoice number where payment was applied.
14. **Refund Amount:** Enter the amount (in U.S. Dollars) that is to be refunded.
15. **Is this a FURLS refund request?** If request is for fees paid for registration within the FDA Unified Registration and Listing System (FURLS), check the appropriate box. If response is "Yes", complete fields (a) through (f). If response is "No", proceed to field 16.

    (a) FURLS Request Type – Check "Used PIN" if PIN was used to register your facility with FDA's Center for Devices and Radiological Health (CDRH). Check "Unused PIN" if PIN was not used to register, and proceed to field 16.

    (b) Registration or Owner/Operator Number – Enter FURLS registration or owner/operator number.

    (c) Why did your facility originally pay the fee? – Provide reason why the user fee was paid.

    (d) Why do you believe your facility is not required to pay the fee? – Provide reason why the facility should not be required to pay the fee.

    (e) List all activities performed at your facility – Provide list of all activities currently performed at your facility (i.e. manufacture medical device, contract sterilizer, etc.).

    (f) List all products manufactured at your facility – Provide list of all products associated with each activity.
16. **Reason for Request:** Provide a brief description of why refund is being requested.
17. **Acknowledgement:** Review acknowledgment, confirming that you are the authorized representative listed on this form and have provided valid contact information in the event that there are questions pertaining to the request.
18. **Signature**: Place signature of listed authorizing official here.

    Date of Signature – Date document is signed by authorizing official.

Section D: FDA Acknowledgement

This section is for FDA use only. An FDA representative will fill out the following items:

19. **FDA Received Date:** Enter date that request was received by FDA.
20. **Center Decision:** Check appropriate box, indicating if request was approved or denied.
21. **If Denied, State Reason:** If response to field 20 was "Denied", provide reason.
22. **Decision Date:** Enter date decision was made.
23. **Center Contact Name:** Enter name of the Center's action officer.
24. **Request Executed:** Check the appropriate box, indicating if request was executed.
25. **If No, State Reason:** If response to field 24 was "No", provide reason.

26. **Final Action:** Check the appropriate box, indicating if request was refunded or not refunded.
27. **Date of Final Action:** Enter date that final action was taken on request.
28. **OFM Contact Name:** Enter name of the OFM action officer.

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 0.40 hours 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 number."