**APPLICATION FORM FOR PROVISIONAL APPROVAL OF CERTIFICATION BODIES**

**Healthcare Textiles Processing Facility Certification (****HEALTEXPROF) Scheme**

Please provide information as per the format and in the space given

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| **SECTION – I GENERAL INFORMATION** | | | | | | | | | |
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| 1. | **Name of the Certification Body** |  | | | | | | | |
|  | | | | | | | | | |
| 2. | **Address of Main Office** |  | | | | | | | |
|  | | | | | | | |
| *City* |  | | | | | | |
| *State* |  | | | *PIN* |  | | |
|  | | | | | | | | | |
| 3. | **Contact Details** | *Phone* |  | | | | | | |
| *E-mail* |  | | | | | | |
| *Web* |  | | | | | | |
|  | | | | | | | | | |
| 4. | **Ownership Details**  **(Pvt, Ltd, LLP etc.)** |  | | | | | | | |
|  | | | | | | | | | |
| 5. | **Legal Registration Details** | *Status* | |  | | | | | |
| *Regn. No.* | |  | | | | | |
| *Date of Regn.* | |  | | | | | |
| *Regn. Authority* | |  | | | | | |
|  | | | | | | | | | |
| 6. | **Address of registered office and Place of Registration\*, if any** |  | | | | | | |
| *\* If registered outside the country where Main Office is located. Also provide above the details of approval to operate or to do business in India / other countries and annex copy of the approval granted.* | | | | | | |
|  | | | | | | | | |
| 7. | **Top Management** | *Name* | |  | | | | |
| *Designation* | |  | | | | |
|  | | | | | | | | |
| 8. | **Primary Contact Person** | *Name* | |  | | | | |
| *Designation* | |  | | | | |
| *Phone* | |  | | | | |
| *Mobile* | |  | | | | |
| *E-mail* | |  | | | | |
|  | | | | | | | | |
| 9. | **Branch Office Location(s) if any** |  | |  |  | |  | |
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| *Mention above all Branch Office locations of the Certification Body and annex details as per the format in Table A.* | | | | | | |
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| **SECTION – II PERSONNEL INFORMATION** | | | | | | |
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| 11. | **Quality Manager or Management Representative** | | *Name* |  | | |
|  | | | | | | |
| 12. | **Personnel of CB**  **(Specific to HEALTEXPROF Scheme)** | | *Managerial Staff* | *Auditors* | *Support Staff* | *Total* |
| Location(s) |  |  |  |  |  |
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| *Mention only numbers above and annex details of key Managerial Personnel and all Auditor at the* *Main Office as well as Branch Office locations (if any pertaining to HEALTEXPROF Scheme) as per the format in Table B.* | | | | | |

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| **SECTION – III OTHER INFORMATION** | | | | |
| 13. | 1. **Accreditation as per ISO/IEC 17065 with Scheme details, if any**   *Please specify Accreditation Cert.*  *No. and Validity Period* |  | | |
|  | | | | |
| 14. | **Other Approval(s) from Govt. or Regulatory Bodies, if any** |  | | |
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| 15. | **Other activities within the same legal entity** |  | | |
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| 16. | **Related Organization(s), if any, and their activities** |  | | |
|  | | | | |
| 17. | **Major Customer in Medical Industry, if any** |  | | |
|  | | | | |
| 18. | **Financial Performance**  (for last 3 financial years)  (As applicable) | *Financial Year* | *Income from Certification* | *Expenditure* |
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| **SECTION – IV DOCUMENTS TO BE SUBMITTED ALONG WITH APPLICATION FORM** | |
| 1. | Organization Registration Certificate & Memorandum / Articles of Association (*copy only*) |
| 2. | Master List of Documents relating to Provisional Approval of CB for HEALTEXPROF Scheme (*with issue and/or revision status*) |
| 3. | Quality Manual in accordance with ISO/IEC 17065, if available |
| 4. | Documentation relating to Provisional Approval of CB for HEALTEXPROF Scheme (Procedures, Competence Criteria of Certification Personnel) |
| 5. | Branch Office(s) to be covered under approval (*list as per format in Table – A*), if applicable |
| 6. | List of Managerial Personnel & Auditors (list as per format in Table – B) |
| 7. | Application Fee - Amount, Cheque / DD No., Date: |
| 8. | Document Review Report (DRR) for Provisional Approval of CBs (as per Scheme Requirements) |
| 9. | Evidence of all qualification, experience and training for certification body managerial personnel & Auditors |
| 10. | Other Documents if any |

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| **SECTION –V** | **DECLARATION** |
| I, the Authorized Representative on behalf of our Certification Body, agree to the following Terms & Conditions of AMTZ as well as Rules and Procedures for AMTZ Approval under the Provisional Approval of CB for HEALTEXPROF Scheme, and declare the following:   1. All statements, information and documents provided along with this application are correct to the best of our knowledge and belief. 2. HEALTEXPROF Scheme criteria, requirements, procedures and documents have been read, understood and implemented. 3. Have adequate resources to undertake certification work under the Provisional Approval of CB for HEALTEXPROF Scheme, undergo assessment as well as maintain conditions for approval, and shall pay all necessary fee and charges (including any applicable taxes) to AMTZ. 4. Shall always provide, or give access to, all documents, records, information and facilities during the entire assessment process to enable a thorough assessment of our inspection body and also later during the period of approval. 5. Shall take adequate and prompt corrective and/or preventive action(s) as may be necessary on the issues raised by AMTZ. 6. Shall immediately notify AMTZ of any significant changes in organizational status/structure, operations, facilities, main policies, procedures, staff or competence, which are likely to affect our approval. 7. Shall undertake routine assessment, surveillance & reassessment as scheduled by AMTZ and also the verification or surprise visits as decided by AMTZ. 8. Any fee and charges payable by our certification body and which remains unpaid shall be recovered from our certification body with late payment charges as appropriate and decided by AMTZ. 9. Shall ensure that the operations, staff and procedures of our certification body will always continue to comply with the HEALTEXPROF Scheme requirements and procedures. 10. Shall always maintain impartiality and integrity in operations as well as in certification work. 11. If our certification body at any time is found not complying with the above declaration or the requirements of AMTZ as applicable or is found misrepresenting or misusing approval or carrying out malpractices or bringing AMTZ into disrepute, any action against our certification body may be taken including suspension, withdrawal or debar as deemed appropriate by AMTZ. 12. If any information given along with this application is later found to be false, AMTZ may decide to cancel your application. In such case, the application fee submitted will not be refunded. 13. We shall obtain accreditation from IAF MRA Accreditation Body as per ISO/IEC 17065 within a year from the date of provisional approval by AMTZ. | |
|  | **Authorized Representative** |
| *Signature* |  |
| *Name* |  |
| *Designation* |  |
| *E-mail* |  |
| *Date* |  |
| *Place* |  |

**Important Instructions:**

To apply for AMTZ Provisional Approval of Certification Bodies for HEALTEXPROF Scheme, please complete this application form and send it to AMTZ at the address mentioned below accompanied by:

1. Documents as listed in SECTION IV of application;
2. Application Fee (with applicable taxes) in favour of AMTZ.

Address: AMTZ Campus Pragati Maidan VM Steel Project S.O Visakhapatnam, Pin -530031 Andhra Pradesh - India

NOTE:

1. Before completing this application, form and submitting application, relevant Provisional approval of CB for Biomedical Equipment Maintenance Scheme documents should be carefully studied. If any clarification is needed, please contact AMTZ.
2. If additional space is required for providing information to any item, the information may be annexed as a separate sheet.

**TABLE-A**

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| **CERTIFICATION BODY BRANCH OFFICE LOCATION(S)** | | | |
| **S. No.** | **Branch Office location with complete address** | **Phone, Fax & E-mail; Local Contact Person (with Designation)** | **Activities Performed** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |

**TABLE-B**

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| --- | --- | --- | --- |
| **CERTIFITION BODY MANAGERIAL PERSONNEL & AUDITORS** | | | |
|  | | | |
| **S. No.** | **Name with Designation** | **Qualifications & Years of Relevant Experience** | **Location** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |

**Note:** Evidences of all qualification, experience and training provided shall be made available for review to the scheme owner AMTZ