**Notice of Change Number:**       **Date** (YYYY/MM/DD)**:**

Auditing Organization:

AOID#:

Contact Person:

 Phone:

 Fax:

 Email:

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| **Type of change** |
| [ ]  New name[ ]  Move of head office to another location[ ]  New owner or headquarters[ ]  Change of regulatory correspondent or contact information[ ]  Change of top management[ ]  Move of critical location[ ]  Additional critical location[ ]  Change of activity at critical location[ ]  Additional medical device technical areas[ ]  Change of management system manual, management processes or operational processes*[ ]* Other:       |

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| **Effective date of the change** (YYYY-MM-DD) |
|       |

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| **Description of the change planned/comparison old-new** |
|       |

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| **Reason for the change** |
|       |

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| **Impact of the change** |
|       |

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| **List of supporting documents provided** |
|       |

Date (YYYY-MM-DD) Name/ Signature