Company Name:………………………………………………………………………………

Postal Address:….……………………………………………………….……………………

Location Address: ………………………………………………………………………….…

Telephone number(s): …..…………………………………..………………………………

Product (s)…………………………………………………………………………………..

Number of participants: ..………………………………..…………………………………..

Participants designation:………………………………………………………………..

**Type of Training: Please select the type of training you are requesting for**

* Good Manufacturing Practices
* Good Hygienic Practices
* Good Storage Practices

|  |  |  |  |
| --- | --- | --- | --- |
|  | **FOOD AND DRUGS AUTHORITY** | **DOC. TYPE: FORM** | |
| **DOC NO.: FDA/CSD/FOR – 01** | |
| Page **1** of **2** | **Ver. No.: 02** |
| **Effective Date: 02/09/2024** | |
| **TITLE: TRAINING REQUEST FORM** | | | |

* Good Distribution Practices

This document

ed information

is a property of

Food and Drugs Authority.

Disclosure of

the contents to any third party without written consent of the

Authority

is forbidden.

* HACCP
* Food Safety Supervisors’ Training Course

Other (please state)

………………………………………………………………………………………

Mode of Training: a) in person b) Online

If Online, provide Preferred date of Training: ………………………. Time: …………….

WhatsApp/email: ……………………………………………………………………….………..

Name of Contact Person: ….…………………………… Tel No.: …………………………

Current Position:………………………………………………………………………………

Client Signature:……………………………………… Date:..…….……………….……….

**FOR OFFICE USE ONLY**

Amount to be paid……………………………………………………….…………………… Received by (FDA staff):…………………………………… Date:…………………………

|  |  |  |  |
| --- | --- | --- | --- |
|  | **FOOD AND DRUGS AUTHORITY** | **DOC. TYPE: FORM** | |
| **DOC NO.: FDA/CSD/FOR – 01** | |
| Page **2** of **2** | **Ver. No.: 02** |
| **Effective Date: 02/09/2024** | |
| **TITLE: TRAINING REQUEST FORM** | | | |

This document

ed information

is a property of

Food and Drugs Authority.

Disclosure of

the contents to any third party without written consent of the

Authority

is forbidden.

Transflowpay Bill Number ………………………………… Date………………………… FDA Receipt Number…………………………………….