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**  |
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* Good Distribution Practices

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