Medical Devices Destruction Supervision Form

Facility Details			
Facility Name			
Facility Type	**Healthcare Facility**		**Authorized Representative**
Address			
CR No.		**NHRA License No. (if any)**	
Contact Person			
Telephone No.		**Mobile No.**	
Email Address			

Medical Device Details *(if more than one, please attach Excel Sheet)*			
Medical Device Name		**Model**	
Intended Use			
Manufacturer Name		**CoO**	
Serial No.		**Lot No.**	
NHRA Registration Certificate No. (if any)			
Quantity to be destructed			
End-user (if any)	**Attach Acknowledgment**		
Supreme Council of Environment Approval (if required)	**Attach**		
Reason of Disposal	□ Defected / (Recalled). □ Closure of manufacturer facility □ Clinically / technically obsolete. □ Unavailable spare parts. □ Damaged/inaccurate / expired. □ Absence of manufacturer/supplier support. □ Others (----------)		

Destruction Company Details	
Company Name	
Address	
CR No.	
Telephone No.	
Email Address	

I hereby declare that all the above information is correct and accurate, and all the required documents will be submitted upon request.

Authorized Person Name: ----------

Signature ----------

Stamp:

Your cooperation is highly appreciated in improving health services in the Kingdom of Bahrain.