nhra BAHRAIN الهيئة الوطنية لتنظيم المهن والخدمات الصحية NATIONAL HEALTH REGULATORY AUTHORITY

Medical Devices Destruction 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**	
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). ☐ Clinically / technically obsolete. ☐ Damaged/inaccurate ☐ Absence of manufacturer/supplier support. ☐ Others (---)	☐ Closure of manufacturer facility ☐ Unavailable spare parts.	

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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:

**In case of the electronic stamp and signature are not available, Please provide a declaration letter stating that all the provided information in the above or attached form are correct and authentic*

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

E-Mail: medical_devices@nhra.bh **Website:** www.nhra.bh **Tel.:** 17113299 /**P.O. Box:** 11464