

**XYZ Pharmaceutical (Pvt) Ltd.**

Logo	Title: SOP Name	Document Number	XY/QA/SOP/001 (Annex.I)
		Revision Number	00
		Effective Date	DD-MM-YYYY
		CCF No.	CCF /001/YYYY
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**CHANGE CONTROL FORM (CCF)**

**Proposed Change:**

**Current Method which will be replaced by new change**

**Effective Document(s) to be amended**

**Reason for Change**

**Proposed By:**

	Name	Signature	Date
Initiator			
HOD			

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**MANAGEMENT REVIEW**

Circulated To: ----- Date: -----

Review of impact of CCF

Comments	Reviews

Cost/Productivity approval (Applicable/ Not Applicable)

Sign/Date: -----

**ASSESSMENT AND AUTHORIZATION OF CCF**

Date of review: Feasibility of Change: (Yes) (No)

Category of Change: (A) (B) (C)

Date of regulatory authority approval (Applicable/ Not Applicable) Date: -----

Signature of Manager Quality or regulatory affairs -----

QA approval: ----- Date: -----

Final Approval and authorization

CEO/Director	Signature	Date

Date of Implementation of amended document: -----

Amended Document Distribution Date: -----