***ANNEXURE 02***

***Recommended Authorized Signatories***

(For Medical / Clinical Testing Laboratories)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SI No** | **Name & Designation of Signatory** | **Qualification** | | | **Experience in years related to present work** | **Relevant Training** | **Part time/Full time (timings if part time)** | **Authorized for which specific area of testing/providing opinion or interpretation/ issuing compliance certification** | ***Specimen Signature*** | ***For internal use only*** |
| **Qualification with Specialization** | **Name of the institute** | **SLMC registration**  **No.** | ***Compliance to SLAB minimum competency requirements as per***  ***ML-GL(P)-02 (Yes/No)*** |
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Note 1: Please provide details separately for each field of testing

Note 2: Please specifically indicate if any contracted personnel, under Name and Designation of Signatory column

Note 3: Any change in the Authorized signatories shall be informed by the laboratory to SLAB within one month and for new signatories this format shall be submitted

Note 4: Please attach updated CV of all signatories with the recommendation of Head of the Institution.

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| **SI No** | **Name & Designation of Signatory** | **To be filled by the Technical Assessor(s) / Technical Expert(s)/Assessor(s)** | | | | | | | |
| **Knowledge of Quality Management System** | | **Knowledge on Laboratory Operations** | **Knowledge on Quality Assurance and traceability** | | **Knowledge on the validity of Technical results** | **Changes if any, observed at the 1st surveillance assessment /**  **2nd surveillance assessment** | |
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| **Signature, Name and Designation of Head of Laboratory** | | | **Signature and Name of Technical Assessor(s) / Technical Expert(s)/Assessor(s)** | | | **Signature and Name of Team Leader** | | |  | |

**For Internal use only**