 **SRI LANKA ACCREDITATION BOARD**

**for CONFORMITY ASSESSMENT**

**APPLICATION FORM**

***for* accreditation *of* PROFICIENCY TESTING PROVIDERS**

***Instructions to the Applicant:***

1. Please submit the duly filled application along with all annexures. along with the Self-Assessment Checklist (PT-FM(P)-11), documents and records referred in the application and Self- Assessment Checklist.
2. Please read Rules and procedures for TL/ CL/ ML/ IB/ PTP/ RMP/ GLP (AC-RG (P)-26), Terms and Conditions for use of Accreditation Symbol (AC-RG (P)-01), List of procedures, relevant specific criteria documents before filling the application.
3. Please submit soft copies of application and related documents with all annexures 1-7



Director /CEO,



Sri Lanka Accreditation Board for Conformity Assessment,

No.44, Dedicated Economic Center

Kirimandala Mawatha, Narahenpita

**APPLICATION FOR ACCREDITATION of PROFICIENCY Testing PROVIDERS**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| We apply for SLAB accreditation of our **Proficiency** **testing schemes** as per details given below: | | | | | | | |
|  | |  | |  |  |  | |
| First Accreditation |  | |  | 1. Scope Extensionin the existing accredited scheme / field | | |  |
|  |  | |  |  | | |  |
| Renewal of Accreditation |  | |  | 1. Scope extension in new scheme / field | | |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **1. Proficiency Testing Provider’s Details** | | | | | | | |
|  | | | | | | | |
|  | **Name of the Proficiency Testing Provider** | | |  | | | |
| Address | |  | | | | | |
| Telephone | |  | | | | Fax No |  |
| e-mail | |  | | | |  |  |
|  | | |  | | |  |  |
| **1.2.** | **Name of Parent Organization (if part of an organization)** | | | |  | | |
| Address | |  | | | | | |
| Telephone | |  | | | | Fax No |  |
| e-mail | |  | | | |  |  |
|  | | |  | | |  |  |
| **1.3.** | **Legal status and date of establishment**(Please provide copy of registration / Relevant section of act or regulation) | | | |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **1.4.** | | **Does the Proficiency Testing Provider undertake following PT activities?**  (If yes, please clearly indicate in the scope of accreditation, para 2.3, the PT activities conducted) | | | | | |
|  |  | |  | |  |  |  |
|  | | 1. Site Facility (when undertaking PT activities at sites) |  | Yes | |  | No |
|  | |  |  |  | |  |  |
|  | | 1. Temporary Facility (when a facility is created temporarily) |  | Yes | |  | No |
|  | |  |  |  | |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.5.** | | **Customers’ of PT Schemes**(Please indicate the percentage in the appropriate box) | | | | | | | | | | | | |
|  |  | |  | | |  |  | | |  |  | |  | | |  |
|  | | open to others |  |  | partly open to others | | |  |  | within the internal group | | | |  |
|  | |  |  |  |  | | |  |  | | |  | |  |
|  | | percentage |  |  | percentage | | |  |  | percentage | | | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.6.** | *Is Proficiency Testing Activities obtaining any laboratory activities from external providers (eg: Subcontracting of testing/ inspection/calibration or part of PT programmes, data analysis) pertaining the scope applied?* | | | | | | | | | | | | | | |
|  |  | |  | |  | |  |  | |  | | | |  | |
|  | Yes | |  | |  | | No |  | |  | | | |  | |
|  |  | | | | | | | | | | | | | | |
|  | If yes, please specify the activities obtained from external providers (Please provide details in separate annexure) | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |
| **2.** | **Accreditation Details** | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |
| **2.1.** | **Field of Proficiency Testing for which accreditation is sought** (Please tick the appropriate box)   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Chemical Testing** |  | **Biological Testing** |  | **Mechanical Testing** |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Medical/Clinical Testing** |  | **Calibration** |  | **Inspection** |  | |  |  |  |  |  |  | | **Electrical Testing** |  | **Forensic Testing** |  | **Others, Please specify** |  | | | | | | | | | | | | | | | |
| **2.2** | **If the PT Provider is already accredited, attach the Scope & PT Schemes for which accreditation granted**(Please indicate the Accreditation provider, Accredited Scope, Date of Accreditation and Validity period) | | | | | | | | | | | | | | |
| **2.3.** | **Scope of Accreditation**(Please indicate the Scope which accreditation is sought) ***–*** *Please attach Part A of Annexure 01* | | | | | | | | | | | | | | |
| **2.4.** | **Does the PT Provider perform in-house calibrations?** | | | | | | | | Yes | |  | No |  | |  |
|  |  |  | |  | |  |  | | | | | | | | |
|  | ***If yes –*** *Please attach the details as per Part B of Annexure 01* | | | | | | | | | | | | | | |

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| **3.** | **Organization** | | |  | | | |  | | | |  | |
| **3.1.** | **Senior Management** (Name, Designation) | | | | | | | | | | | | |
|  | 3.1.1. | Chief Executive of the Organization | | | | | | | | | **:** | **………………………………………………** | |
|  | 3.1.2. | Person responsible for the PTP management | | | | | | | | | **:** | **………………………………………………** | |
|  | 3.1.3. | Person/s responsible for technical operations | | | | | | | | | **:** | **………………………………………………** | |
|  | 3.1.4. | Authorized Representative for SLAB | | | | | | | | | **:** | **………………………………………………** | |
|  |  | Telephone: |  | | Fax: |  | | | | | | E-mail |  |
|  |  | Mobile: |  | |  |  | | | | | |  |  |
|  | 3.1.5. | Information regarding any individual or organization that has provided consultancy or following assistance towards SLAB accreditation; | | | | | | | | | | | |
|  |  | Development of Quality Management System | | | | | | | **:** | **……………………………………………………** | | | |
|  |  | Development of Technical Operations | | | | | | | **:** | **……………………………………………………** | | | |
|  |  | Training | | | | | | | **:** | **……………………………………………………** | | | |
|  |  | Conducting Internal Audits | | | | | | | **:** | **……………………………………………………** | | | |
|  |  | Other | | | | | | | **:** | **……………………………………………………** | | | |
|  | 3.1.6 | Any affiliation or relationships to SLAB | | | | | **:** | | **……………………………………………………** | | | | |

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| **3.2.** | **Organization and Management Structure** | |
|  | 3.2.1. | Indicate in an organization and management structure to the operating departments of the PT Provider for which accreditation is being sought (please append) |
|  | 3.2.2. | Indicate how the PT Provider is related to external organizations or to its own parent organization (where applicable) |

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| **4.** | **Please attach the following documents / records** | |
|  | 4.1. | Annexure 01 - *Scope of Accreditation\** |
|  | 4.2. | Annexure 02 - Authorized signatories for issue of PT reports\* |
|  | 4.3. | Annexure 03 - Details of staff |
|  | 4.4. | Annexure 04 - Equipment List, if applicable |
|  | 4.5. | Annexure 05 - List of reference materials, if applicable |
|  | 4.6. | Annexure 06 - Internal and External Quality Assurance Programmes, if applicable |
|  | 4.7. | Annexure 07 - Self-Assessment Checklist\* |
|  | 4.8. | Organization and management structure |
|  | 4.9 | Management system documentation |
|  | 4.10. | Evidence for legal status |
|  | 4.11. | Summary of recently conducted PT Programmes and relevant PT plans |
|  | 4.12 | Proficiency Testing Programme Schedule for the current year and next three years |
|  | 4.13 | Procedure/s for preparation of proficiency test items |
|  | 4.14 | Procedure/s for establishment of homogeneity and stability of PT items |
|  | 4.15 | Procedure/s for assigned values |
|  | 4.16 | Procedure/s for data analysis |
|  | 4.17 | Report of the last internal audit together with corrective action records |
|  | 4.18 | Minutes of the last management review |
|  | 4.19 | Two signed copies of Terms and Conditions for maintaining accreditation TL/ CL/ ML/ IB/ PTP/ RMP/ GLP (AC - RG (P) – 08) |

**5. Willingness to undergo Assessment**

**We declare that**

* We are aware of and will abide by the Terms and Conditions for maintaining accreditation TL/ CL/ ML/ IB/ PTP/ RMP/ GLP (AC - RG (P) – 08) to be signed by both parties, which is enclosed.
* We agree to comply fully and continually fulfill the requirements of ISO/IEC 17043, ILAC and SLAB requirements for the accreditation of proficiency testing providers.
* We agree to comply with accreditation procedures and pay all costs for activities related to accreditation process as per Terms and Conditions for maintaining accreditation TL/ CL/ ML/ IB/ PTP/ RMP/ GLP (AC-RG(P)–08) & Fee Structure (PT-RG(P)-01) available at SLAB website: [www.slab.lk](http://www.slab.lk)
* We agree to co-operate with the assessment team appointed by SLAB for examination of all relevant documents by them and their visits to those parts of the PT Providers that are part of the scope of accreditation.
* We declare that all the information provided is true and accurate to the best of our knowledge. We are aware that giving any fraudulent information will lead to termination of the accreditation process.

|  |  |
| --- | --- |
| Signature of Chief Executive |  |
| Name & Designation |  |
| Date & Place |  |

…………………………………………………………………………………

***For office use only***

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| A. | | Check whether the following have been submitted | | | | | **To be checked by the Management Assistant** | | | **To be checked by the TM/Authorized Officer** |
|  |  | | | | | | **Softcopy** | | |  |
|  | Annexure 01 -Scope of Accreditation | | | | | |  | | |  |
|  | Annexure 02 - Authorized signatories for issue of PT reports | | | | | |  | | |  |
|  | Annexure 03 - Details of staff | | | | | |  | | |  |
|  | Annexure 04 - Equipment List, if applicable | | | | | |  | | |  |
|  | Annexure 05 - List of reference materials, if applicable | | | | | |  | | |  |
|  | Annexure 06 - Internal and External Quality Assurance Programmes, if applicable | | | | | |  | | |  |
|  | Annexure 07 - Self-Assessment Checklist\* | | | | | |  | | |  |
|  | Organization and management structure | | | | | |  | | |  |
|  | Evidence for legal status | | | | | |  | | |  |
|  | Summary of recently conducted PT Programmes and PT plans | | | | | |  | | |  |
|  | Management System Documentation | | | | | |  | | |  |
|  | Proficiency Testing Programme Schedule for the current year and next three years | | | | | |  | | |  |
|  | Procedure/s for preparation of proficiency test items | | | | | |  | | |  |
|  | Procedure/s for establishment of homogeneity and stability of PT items | | | | | |  | | |  |
|  | Procedure/s for assigned values | | | | | |  | | |  |
|  | Procedure/s for data analysis | | | | | |  | | |  |
|  | Report of the last internal audit together with corrective action records. | | | | | |  | | |  |
|  | Minutes of the last management review | | | | | |  | | |  |
|  | Two signed copies of Terms and Conditions for maintaining TL/ CL/ ML/ IB/ PTP/ RMP/ GLP (AC-RG(P)–08) | | | | | |  | | |  |
|  | |  | | | |  | | |  | |
| |  |  |  | | --- | --- | --- | | ***Case file number:***  **PT** | *Assigned by* | *Verified by* |   **To be filled by the Technical Manager / Deputy Technical Manager before assigning the application to Authorized officer**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | A. | Comments on the case file | : |  | | | | B. | Allocation of Case file | : |  | | | | C. | Allocation for Document and Record Review | | | : |  |   Date: …………………… Technical Manager/Deputy Technical Manager: ………………………  **To be filled by the Authorized officer** | | | | | | | | | | |
| A. | | Check whether the SLAB fulfills the following   |  |  | | --- | --- | | Is the activity area of CAB under the purview of SLAB | Yes / No | | Can the initial assessment be performed in a timely manner | Yes / No | | If yes, state the duration |  | | Has the SLAB Competence on accrediting the CAB | Yes / No | | | | | | | | | |
| B. | | Are all functions of CAB performed at one site  If No, indicate the specific activities | | | | Yes / No | | | | |
|  | |  | | | |
| C. | | Time estimation (Number of man days) for initial assessment | | | : | | |  | | |
|  | |  | | |  | | |  | | |
| D. | | Remarks of Authorized Officer | : |  | | | | | | |
|  | | Date: …………………… Authorized Officer: ……………………… | | | | | | | | |