

Method of filling: all the fields to be completed, use tick mark (✓/☒) where appropriate, where not applicable put N.A. or “_”

1. DATA OF ORGANISATION APPLYING FOR CERTIFICATION –

Organization name:	
Address of site to be audited:	
Office address:	
Contact person with designation:	
Telephone / Mobile:	
E-Mail Id and Web-site if any:	
GSTIN Number:	

2. COMPANY STRUCTURE –

Legal status: Proprietary Partnership Pvt. Ltd. Limited Trust

If any branch offices, subsidiary company / Group companies: Yes no

Any legal (Statutory and Regulatory) obligations applicable to your product/ service ? Yes no
(If yes please specify):

3. CERTIFICATION REQUIREMENT – Please Tick mark (✓/☒)

Type of certification requested: FIRST CERTIFICATION, RECERTIFICATION, EXTENSION [Special audit (SCOPE SITE)], TRANSFER OF CERTIFICATE (CHANGE OF CB)

Standard applied for: ISO 9001: 2015 or Other _____

Accreditation requirement: NABCB or Other _____

Please mention your requirement regarding Scope / Activity to be certify:

4. IS YOUR ORGANISATION HAVING MULTISITE? Yes no

If yes please specify what functions are performed centrally (eg. Marketing, Purchasing, Top Management, HR, Contract review, Customer Care etc...):-

List all site/s to be covered (Please use hierachal structures i.e. firstly mention central office/Head office then other sites):

Site	Address of site/s	Processes/Operations/ Function	Nº employees
Site 1			
Site 2			
Site 3			

Note : For more sites may attach annexure with the same formatting as above.

5. FOR THE EMPLOYEE STRUCTURE OF ORGANISATION. (Employee information by as per each Site and Shift wise)

Site: 1 (For additional Sites please attach annexure in the same format.)								
Department		General shift		IF ORGANISATION WORKING UNDER SHIFT				
		Permanent	Contract	Shift I	Shift II	Shift III	Per.	Contract
Top management, Administrative staff (for Marketing, HR, Purchase, Design and development, etc...)								
Production/ Quality	Management and Supervisory Staff							
	Operators							
	Helpers							
Others if any _____								
Others if any _____								
*Total N° Employee								

Note: Personnel involved in the management system is meant partners + employees + collaborators + subcontractors, etc. (The total staff in head office + personnel of any sites to be certified + yard personnel if any)

Onsite installation work or having any other operational yards / temporary sites? <input type="checkbox"/> Yes <input type="checkbox"/> no
If yes Please Explain:
Any part time personnel? <input type="checkbox"/> Yes <input type="checkbox"/> no
If Yes Please specify N° of personnel _____
Are there any employees that you did not include in the above-mentioned tables because you consider them to be outside the scope of the audit? <input type="checkbox"/> Yes <input type="checkbox"/> no
If yes Please Explain:

Have any management system consultancy services taken? : <input type="checkbox"/> Yes <input type="checkbox"/> no
If yes, by whom?-
And period of services:

6. Describe your organization.
Describe your organization is: <input type="checkbox"/> Manufacturer / <input type="checkbox"/> Service provider
Major customers:
Main products:
Main raw materials used or processed:
Operations involved in the service / manufacturing of your product:
Processes which are provided by external sources related to the product / service:

Who designs the products / services that you provide to your customers? Please Tick mark (✓/☒)	<input type="checkbox"/> We manufacture the product as per customers provided designs and specification. <input type="checkbox"/> We design our own products. <input type="checkbox"/> We design products at another Site and produce at the site to be certified. <input type="checkbox"/> We outsource design activities to external providers/ subcontractors. <input type="checkbox"/> We are a distributor of products that are designed and manufactured by another company.
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7. Does the company have any other valid certificate/s? : Yes No. If yes, please list below.

Sr .	Certification body	Accreditation	Validity until	Certificate/s number
1.				
2.				

Date of system implementation:

Please mention your proposed month-year to conduct the audit:

Note –

- Initial audit will be conducted in two stages. Stage 2 audit date /s will be finalised on assessment of stage I audit.
- If available, Please attach: Process flow diagram, organisation brochure, customer specific requirements.

Sign with duly stamped (We herewith confirm the completeness and accuracy of the information given above.)	Name:
	Designation:
	Date:

FOR COMMUNICATION TO AITF- REGISTERED OFFICE ADDRESS:

A.I.T.F. MANAGEMENT CERTIFICATION LIMITED

Devi Indrayani Wing B 26, Gat No. 382+3+4/1, Talawade, Pune – 411 062. Maharashtra, India.

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(CERTIFICATION MANAGER)