



REPUBLIC OF THE PHILIPPINES
DEPARTMENT OF HEALTH
BUREAU OF FOOD AND DRUGS

Civic Drive, Filinvest Corporate City
Alabang, Muntinlupa City
Tel. No.: 807-0721
Website: www.bfad.gov.ph



MALAYA AT MALUSOG
NA PAMAYANAN

24 October 2005

BUREAU CIRCULAR

No. 20 s. 2005

SUBJECT: Revised Assessment Slips

For the effective and efficient processing of applications and other requests, all applicant companies and all concerned are directed to use the attached Revised Assessment Slips. The Product Information Fields will be filled-out by the Applicant and all the remaining fields by the Bureau.

Annex A	Drug / Vaccine / Veterinary / Herbal
Annex B	<i>In Vitro</i> Diagnostic Reagent / Medical Device / Medical Gas
Annex C	Cosmetics / Household Hazardous Substances
Annex D	Food

The assessment slips are available at the PPAD-PAICS and can also be downloaded from the BFAD Website (www.bfad.gov.ph).

This Order shall take effect on **14 November 2005**.


PROF. LETICIA-BARBARA B. GUTIERREZ, MS
Director

PAICS COPY

ACCOUNTING SECTION'S COPY

Bureau of Food and Drugs
 Policy, Planning, and Advocacy Division
 A S S E S S M E N T S L I P
 DRUG / VACCINE / VETERINARY / HERBAL

Bureau of Food and Drugs
 Policy, Planning, and Advocacy Division
 A S S E S S M E N T S L I P
 DRUG / VACCINE / VETERINARY / HERBAL

DATE: _____ RSN: _____

PRODUCT INFORMATION

Generic Name _____

Brand Name _____

Dosage Form and Strength _____

Packaging _____

Pharmacologic Category _____

Registration Number _____

Essential Drug Yes No

Applicant Company _____

Manufacturer _____

Packer _____

Repacker _____

Trader _____

Importer _____

Exporter _____

Distributor _____

Suggested Retail Price _____

Number of Samples _____

APPLICATION DETAILS

Application Type	New Drug	Generic	Branded
Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal with Surcharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-application (OLD RSN _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitored Release Extension (MRE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of CPR Validity Applied for (year/s) _____			

OTHER REQUESTS

Amendment of CPR

Brand name clearance

Re-issuance/Reconstruction of CPR

Accreditation of BE Center

Certifications

Provisional Permit to Carry

Export Certificate

Others, pls. specify _____

PAYMENT DETAILS

EVALUATOR

Fee _____

Amount _____

Surcharge _____

OR Number _____

TOTAL _____

Date Issued _____

Evaluated by _____

Received by _____

RECEIPT DETAILS

Name _____

Signature _____

DATE: _____ RSN: _____

PRODUCT INFORMATION

Generic Name _____

Brand Name _____

Dosage Form and Strength _____

Packaging _____

Pharmacologic Category _____

Registration Number _____

Essential Drug Yes No

Applicant Company _____

Manufacturer _____

Packer _____

Repacker _____

Trader _____

Importer _____

Exporter _____

Distributor _____

Suggested Retail Price _____

Number of Samples _____

APPLICATION DETAILS

Application Type	New Drug	Generic	Branded
Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal with Surcharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-application (OLD RSN _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitored Release Extension (MRE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of CPR Validity Applied for (year/s) _____			

OTHER REQUESTS

Amendment of CPR

Brand name clearance

Re-issuance/Reconstruction of CPR

Accreditation of BE Center

Certifications

Provisional Permit to Carry

Export Certificate

Others, pls. specify _____

PAYMENT DETAILS

EVALUATOR

Fee _____

Amount _____

Surcharge _____

OR Number _____

TOTAL _____

Date Issued _____

Evaluated by _____

Received by _____

RECEIPT DETAILS

Name _____

Signature _____

Bureau of Food and Drugs
Policy, Planning, and Advocacy Division

A S S E S S M E N T S L I P

IN VITRO DIAGNOSTIC REAGENT / MEDICAL DEVICE / MEDICAL GAS

Bureau of Food and Drugs
Policy, Planning, and Advocacy Division

A S S E S S M E N T S L I P

IN VITRO DIAGNOSTIC REAGENT / MEDICAL DEVICE / MEDICAL GAS

DATE: _____ RSN: _____

DATE: _____ RSN: _____

PRODUCT INFORMATION

PRODUCT INFORMATION

Product Name _____
 Brand Name _____
 Sizes _____

 Packaging _____
 Registration Number _____
 Applicant Company _____
 Manufacturer _____
 Packer _____
 Repacker _____
 Trader _____
 Importer _____
 Exporter _____
 Distributor _____
 Suggested Retail Price _____
 Number of Samples _____

Product Name _____
 Brand Name _____
 Sizes _____

 Packaging _____
 Registration Number _____
 Applicant Company _____
 Manufacturer _____
 Packer _____
 Repacker _____
 Trader _____
 Importer _____
 Exporter _____
 Distributor _____
 Suggested Retail Price _____
 Number of Samples _____

APPLICATION DETAILS

APPLICATION DETAILS

Initial
 Renewal
 Renewal with Surcharge
 Re-application (OLD RSN) _____
 No. of CPR Validity Applied for (year/s) _____

Initial
 Renewal
 Renewal with Surcharge
 Re-application (OLD RSN) _____
 No. of CPR Validity Applied for (year/s) _____

OTHER REQUESTS

OTHER REQUESTS

Amendment of CPR
 Brand name clearance
 Re-issuance/Reconstruction of CPR
 Certifications

Amendment of CPR
 Brand name clearance
 Re-issuance/Reconstruction of CPR
 Certifications

PAYMENT DETAILS

PAYMENT DETAILS

EVALUATOR
 Fee _____
 Surcharge _____
 TOTAL _____
 Evaluated by _____

EVALUATOR
 Fee _____
 Surcharge _____
 TOTAL _____
 Evaluated by _____

RECEIPT DETAILS

RECEIPT DETAILS

Name _____
 Signature _____

Name _____
 Signature _____

CASHIER

CASHIER

Amount _____
 OR Number _____
 Date Issued _____
 Received by _____

Amount _____
 OR Number _____
 Date Issued _____
 Received by _____

Provisional Permit to Carry

Export Certificate

Others, pls. specify

PAICS COPY

Bureau of Food and Drugs
 Policy, Planning, and Advocacy Division
A S S E S S M E N T S L I P
 COSMETICS / HOUSEHOLD HAZARDOUS SUBSTANCES

DATE: _____ RSN: _____

PRODUCT INFORMATION

Product Name _____

Product Type _____

Variant / s _____

Packaging _____

Registration Number _____

Applicant Company _____

Manufacturer _____

Packer _____

Repacker _____

Trader _____

Importer _____

Exporter _____

Distributor _____

Number of Samples _____

APPLICATION DETAILS

Application Type	Cosmetic Regular	Cosmetic Listing/Notification	Household Hazardous
Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal with Surcharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-application (OLD RSN _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Export	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of CPR Validity Applied for (year/s) _____			

OTHER REQUESTS

Amendment of CPR Certifications

Re-issuance/Reconstruction of CPR Others, pls. specify _____

PAYMENT DETAILS

EVALUATOR

Fee	Amount	CASHIER
Surcharge	OR Number	Amount
TOTAL	Date Issued	OR Number
Evaluated by	Received by	Date Issued
		Received by

RECEIPT DETAILS

Name _____

Signature _____

ACCOUNTING SECTION'S COPY

Bureau of Food and Drugs
 Policy, Planning, and Advocacy Division
A S S E S S M E N T S L I P
 COSMETICS / HOUSEHOLD HAZARDOUS SUBSTANCES

DATE: _____ RSN: _____

PRODUCT INFORMATION

Product Name _____

Product Type _____

Variant / s _____

Packaging _____

Registration Number _____

Applicant Company _____

Manufacturer _____

Packer _____

Repacker _____

Trader _____

Importer _____

Exporter _____

Distributor _____

Number of Samples _____

APPLICATION DETAILS

Application Type	Cosmetic Regular	Cosmetic Listing/Notification	Household Hazardous
Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal with Surcharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-application (OLD RSN _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Export	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of CPR Validity Applied for (year/s) _____			

OTHER REQUESTS

Amendment of CPR Certifications

Re-issuance/Reconstruction of CPR Others, pls. specify _____

PAYMENT DETAILS

EVALUATOR

Fee	Amount	CASHIER
Surcharge	OR Number	Amount
TOTAL	Date Issued	OR Number
Evaluated by	Received by	Date Issued
		Received by

RECEIPT DETAILS

Name _____

Signature _____

ACCOUNTING SECTION'S COPY

Bureau of Food and Drugs
Policy, Planning, and Advocacy Division
ASSESSMENT SLIP
FOOD

DATE: _____ RSN: _____

PRODUCT INFORMATION

Product Name: _____

Product Code: _____

Packaging: _____

Registration Number: _____

Applicant Company: _____

Manufacturer: _____

Packer: _____

Repacker: _____

Trader: _____

Importer: _____

Exporter: _____

Distributor: _____

Number of Samples / Loose Labels: _____

APPLICATION DETAILS

Application Type	Category I	Category II	Food Supplement	Bottled Water
Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal with Surcharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-application (OLD RSN: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of CPR Validity Applied for (year/s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER REQUESTS

Amendment of CPR

Re-issuance/Reconstruction of CPR

Referral to ACB

Certifications

Provisional Permit to Market (PPM)

Provisional Permit to Carry

Export Certificate

Others, pls. specify _____

PAYMENT DETAILS

EVALUATOR

Fee: _____

Surcharge: _____

TOTAL: _____

Evaluated by: _____

RECEIPT DETAILS

CASHIER

Amount: _____

OR Number: _____

Date Issued: _____

Received by: _____

Name: _____

Signature: _____

PAICS COPY

Bureau of Food and Drugs
Policy, Planning, and Advocacy Division
ASSESSMENT SLIP
FOOD

DATE: _____ RSN: _____

PRODUCT INFORMATION

Product Name: _____

Product Code: _____

Packaging: _____

Registration Number: _____

Applicant Company: _____

Manufacturer: _____

Packer: _____

Repacker: _____

Trader: _____

Importer: _____

Exporter: _____

Distributor: _____

Number of Samples / Loose Labels: _____

APPLICATION DETAILS

Application Type	Category I	Category II	Food Supplement	Bottled Water
Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renewal with Surcharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-application (OLD RSN: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of CPR Validity Applied for (year/s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER REQUESTS

Amendment of CPR

Re-issuance/Reconstruction of CPR

Referral to ACB

Certifications

Provisional Permit to Market (PPM)

Provisional Permit to Carry

Export Certificate

Others, pls. specify _____

PAYMENT DETAILS

EVALUATOR

Fee: _____

Surcharge: _____

TOTAL: _____

Evaluated by: _____

RECEIPT DETAILS

CASHIER

Amount: _____

OR Number: _____

Date Issued: _____

Received by: _____

Name: _____

Signature: _____