**ANNEX 2 of gn-24**

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**RELINQUISHING COMPANY DECLARATION FORM**

**Important Notes:**

1. This form should be duly completed and signed by a Company Director or senior officer of the *Relinquishing Company*.
2. If the space provided in the form is insufficient, please provide the information as an attachment.

|  |
| --- |
| ***Relinquishing Company*** |
| Name of company |  |
| Company address |  |
| Contact person’s name |  |
| Job title |  |
| Tel no. |  |
| Email Address |  |
| ***Product Owner*** |
| Name of company |  |
| Company address |  |
| Contact person’s name |  |
| Job title |  |
| Tel no. |  |
| Email Address |  |

Please tick one of the following:

[ ]  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Relinquishing *Company)* will retain all records of supply and complaints of the following registered medical device(s). I am obliged to maintain these records for the period stipulated in the *Health Products (Medical Devices) Regulations* and provide such records to the *Accepting Company* or the Authority in the event of a field safety corrective action or when requested by the Authority.

[ ]  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Relinquishing Company) attest that I will transfer all records of supply and complaints of the following registered medical device(s) up to the date of approval of this Change of Registrant application by the Authority, HSA to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of *Accepting Company).*

By signing this, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of *Relinquishing Company*), agree to handover all information and documents submitted to the Authority of the following medical device(s) up to the date of approval of this change of registrant by the Authority, HSA to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of *Accepting Company*).

|  |  |  |
| --- | --- | --- |
| **No.** | **Device Name** | **SMDR Device Registration No.** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

*\* If there are more than 5 medical devices to be transferred, please attach a list to this page*

The effective date of this change of *Registrant* is the date of approval of this Change of *Registrant* application by the Authority, HSA.

|  |  |
| --- | --- |
| Signature |  |
| Full Name of Applicant (as it appears in the NRIC or Passport)  |  |
| Designation |  |
| Company Name and address |  |
| Date(DD/MM/YYYY) |  |