|  |  |
| --- | --- |
| **Purpose** | □ Prospective Validation/Qualification□ Retrospectivex Revalidation |
| **System Description** |

|  |  |
| --- | --- |
| Manufacturer |  |
| Model |  |
| Serial Number(s) |  |

 |
| **Technical Specifications** |

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| **Critical Control Points** |  |
| **Name of SOPs involved** |  |
| **Responsibilities** |  |
| **Installation Qualification** |  |
| **Operational Qualification** |  |
| **Performance Qualification** |  |

 **VALIDATION PLAN APPROVAL**

Signature/Transfusion Service Manager Date

Signature/Transfusion Service Medical Director Date