|  |  |
| --- | --- |
| **Purpose** | □ Prospective Validation/Qualification  □ Retrospective  x Revalidation |
| **System Description** | |  |  | | --- | --- | | Manufacturer |  | | Model |  | | Serial Number(s) |  | |
| **Technical Specifications** | |  |  | | --- | --- | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |
| **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