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| Please state all the locations **belongs to the company** like **head office, factory, branch offices, sales offices, regional offices including transient worksites** where the **same** Quality Management System is processed. If different processes are performed during different shifts, please state those shifts separately. **Number of employees for medical processes** can only be different where other employees are separated by organizational structure and perform **completely** different activities. |

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| **No.** | **Company Name** | **Address** | **Processes** | **Related Products** | **Internal Testing Capabilities for Each Product (If you have, please give the name of the tests and test methods)\*** | **Seasons Which the Company Is Not Active (Holidays, maintenance, etc.)**  **Annual Shut Down/Non-Manufacture Dates** | **Contact Person Name and Contact Information (Tel, e-mail)** | **Number of Shifts** | **Total Number of Employees** | **Number of Employees for Medical Processes** |
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| This form has been filled as the Annex of       dated FR.MED.01 Application Form of the Company. |
| \* If the explanations regarding the test capability do not fit in the specified area, please give relevant information as an attachment. |

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| **Company Representative** | **Name, Surname, Title** | **Signature** | **Date** |
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