CI)	Title	DEVIATION FORM		
MEHA PHARMA Kundaim-Goa	Ref. Doc. No.	SOP/QAD/008		
Deviation No.:			Department	

Description of Deviation:
Source Document:
Product/Material Name/Equipment name (if any):
Batch / Lot No./Equipment ID:
Related to: Process [ ] Equipment [ ] Facility[ ] Analysis[ ] Document [ ] Material [ ]
Other [ ] Other specify (Tick as appropriate)
O <sup>+</sup>
Deviation: PLANNED / UN PLANNED
Reason for deviation:
Reason for deviation:  Reason for deviation:
Brief Investigation:
Initiator Name:DesignationSign / Date:



21/08/2024

Approver-Sign and Date 21/08/2024



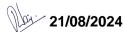
CI)	Title	DEVIATION FORM		
MEHA PHARMA Kundaim-Goa	Ref. Doc. No.	SOP/QAD/008		
Deviation No.:			Department	

Immediate Corrective Action Taken:							
Proposed Corrective Action:							
Little (HOD)							
Initiator (HOD) Name	Docionation		Sign / Date:				
Name	, Designation		, Sign / Date				
	EVALUATION BY 0	QA MANAGER					
Reoccurrence: Yes [ ] No [ ]		- R					
If Yes Previous Deviation No:							
Recurrence Details:		<u>, Q</u>					
	20						
Detailed Investigation required: Ye	es [ ]	No [ ]					
Review of immediate/ Proposed C	Corrective Action by	QA:					
	20						
•							
Potential impact of Deviation upo	n the safety, identity	y, strength, purity & q	uality if any:				
•	•						



21/08/2024

Approver-Sign and Date



(I)	Title	DEVIATION FORM		
MEHA PHARMA Kundaim-Goa	Ref. Doc. No.	SOP/QAD/008		
Deviation No.:			Department	

Impact Assessme	ent:												
Change Control red	quired			:	Yes	[	] N	VО	[	]	NA	[	]
Risk Assessment r	equired			:	Yes	[	] N	No.	[	]	NA	[	]
Process Validation	required			:	Yes	[	] N	No.	[	]	NA	[	]
Cleaning Validation	n required			:	Yes	[	] N	No.	[	]	NA	[	]
Stability Study requ	uired			:	Yes	[	] N	Vo.	[	]	NA	[	]
CAPA required				:	Yes	[	] N	lo	[	]	NA	[	]
Any other:				:	Yes	[	] N	No.	[	]	NA	[	]
Specify:													
Classification: Min	nor[]	Major [	1	Critical [	] ( Ticl	c as	appr	opri	ate)				
Manager-QA				CORT									
Name:		De	signatio	on:		_Sig	gn /	Date	e: _				_
E. EVALUATION E	BY CROSS FU	NCTIONAL T	EAM:	<b>X</b>									
Departments Name		C	ommen	ıts				Sign/Date					
	Name												
Evaluation by Cu	ustomer (If app	olicable)											
Sign/ Date:													
Reviewer-Sign and Date 21/08/2024 Approver-Sign and Date 21/08/2024													

<b>(1)</b>	Title	DEVIATION FORM		
MEHA PHARMA Kundaim-Goa	Ref. Doc. No.	SOP/QAD/008		
Deviation No.:			Department	

APPROVAL BY QA										
The deviation is Approved [ ] Rejected [	( Tick as appropriate)									
Comments (if rejected):										
Recommended Corrective and Preventive Action:(Refer Investigation if applicable):										
Manager -QA (Sign/Date):										
Reference CAPA no. (If applicable)										
Closure by QA (Tick	as	Approp	riate)							
Corrective and Preventive Action Implemented	:	Yes	[ ]	No	[	]	NA	[	]	
New document prepared	:	Yes	[ ]	No	[	]	NA	[	]	
Document revised	:	Yes	[ ]	No	[	]	NA	[	]	
Training Imparted to concerned persons	:	Yes	[ ]	No	[	]	NA	[	]	
Relevant documents attached with deviation	:	Yes	[ ]	No	[	]	NA	[	]	
Implemented CAPA is effective for the system	:	Yes	[ ]	No	[	]	NA	[	]	
Any Other:										
Closure Comments by QA Officer:										
QA Officer Sign/ Date:										
Closure by QA Head:										
QA Head Sign/ Date:										



21/08/2024

