

DEPARTMENT OF HEALTH AND HUMAN SERVICES Food and Drug Administration DHHS/FDA SHELL EGG PRODUCER REGISTRATION (If entering by hand, use blue or black ink only.)	FDA USE ONLY
Date (mm/dd/yyyy)	

Section 1 - TYPE OF REGISTRATION

1a.	<input type="checkbox"/> DOMESTIC REGISTRATION	<input type="checkbox"/> FOREIGN REGISTRATION
1b.	<input type="checkbox"/> INITIAL REGISTRATION	<input type="checkbox"/> UPDATE OF REGISTRATION INFORMATION
	<input type="checkbox"/> NOTIFICATION OF CEASING OPERATIONS AS OF DATE (mm/dd/yyyy): _____	
1c.	If update or ceasing operations notification, provide the Facility Registration Number.	Facility Registration Number
1d.	If update, check all that apply and further identify changes in the applicable sections.	
	<input type="checkbox"/> Facility Name Change	<input type="checkbox"/> Seasonal Facility Dates of Operation Change
	<input type="checkbox"/> Facility Address Change (See instructions)	<input type="checkbox"/> Size of Operation Change
	<input type="checkbox"/> Preferred Mailing Address Change	<input type="checkbox"/> Owner or Operator Change

1e. ARE YOU THE NEW OWNER OF A PREVIOUSLY REGISTERED FACILITY? Yes No
 If "Yes", provide the following information, if known.

Previous owner's name	Previous owner's registration number
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Section 2 - FACILITY NAME / ADDRESS INFORMATION

Facility Name

Facility Street Address, Line 1

PROOF

Facility Street Address, Line 2

City	State (If applicable; if not, skip to Province/Territory)
Province/Territory (If applicable)	ZIP or Postal Code
Country	Phone Number (Include Area/Country Code)
FAX Number (Optional; Include Area/Country Code)	E-Mail Address (Optional)

Section 3 - (OPTIONAL) PREFERRED MAILING ADDRESS INFORMATION - Complete this section only if different from Section 2, Facility Name/Address Information.

Name

Street Address, Line 1

Street Address, Line 2

City State (If applicable; if not, skip to Province/Territory)

Province/Territory (If applicable) ZIP or Postal Code

Country Phone Number (Include Area/Country Code)

FAX Number (Optional; Include Area/Country Code) E-Mail Address (Optional)

Section 4 - (OPTIONAL) SEASONAL FACILITY DATES OF OPERATION - Give the approximate dates that your facility is open for business, if its operations are on a seasonal basis.

Dates of Operation

Section 5 - SIZE OF OPERATION

Average or usual number of layers in each poultry house Number of poultry houses on the farm

Section 6 - OWNER OR OPERATOR INFORMATION

Name of Entity or Individual Who Is the Owner or Operator

PROOF

Provide the following information, if different from all other sections on the form. If the information is the same as another section of the form, check which section.

SECTION 2 SECTION 3

Street Address, Line 1

Street Address, Line 2

City State (If applicable; if not, skip to Province/Territory)

Province/Territory (If applicable) ZIP or Postal Code

Country Phone Number (Include Area/Country Code)

FAX Number (Optional; Include Area/Country Code) E-Mail Address (Optional)

Section 7 - CERTIFICATION STATEMENT

The owner or operator of the facility, or an individual authorized by the owner or operator of the facility, must submit this form. By submitting this form to FDA, or by authorizing an individual to submit this form to FDA, the owner or operator of the facility certifies that the above information is true and accurate. An individual (other than the owner or operator of the facility) who submits the form to the FDA also certifies that the above information submitted is true and accurate and that he/she is authorized to submit the registration on the facility's behalf. An individual authorized by the owner or operator must below identify by name the individual who authorized submission of the registration. Under 18 U. S.C. 1001, anyone who makes a materially false, fictitious, or fraudulent statement to the U.S. Government is subject to criminal penalties.

Signature of Submitter

Printed Name of Submitter

Check One Box

- A. OWNER OR OPERATOR (STOP HERE, FORM IS COMPLETED)
- B. INDIVIDUAL AUTHORIZED TO SUBMIT THE REGISTRATION (FILL IN BELOW)

If you checked Box B above, indicate who authorized you to submit the registration.

- OWNER OR OPERATOR (STOP HERE, FORM IS COMPLETED)
- _____ – NAME OF INDIVIDUAL WHO AUTHORIZED REGISTRATION ON BEHALF OF OWNER OR OPERATOR (FILL IN ADDRESS BELOW)

Address Information for the Authorizing Individual

Authorizing Individual Street Address, Line 1

Authorizing Individual Street Address, Line 2

PROOF

City	State (If applicable; if not, skip to Province/Territory)
Province/Territory (If applicable)	ZIP or Postal Code
Country	Phone Number (Include Area/Country Code)
FAX Number (Optional; Include Area/Country Code)	E-Mail Address (Optional)

MAIL COMPLETED FORM FDA 3733 TO U.S. FOOD AND DRUG ADMINISTRATION, 5600 FISHERS LANE, HFS-681, ROCKVILLE, MD 20857, OR FAX IT TO (301) 436-2804

FDA USE ONLY		
Date Registration Form Received	Date Notification Sent to Facility	Facility Status (Check one)
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive

Public reporting burden for this collection of information is estimated to average 2.3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
1350 Piccard Drive, 420A
Rockville, MD 20850

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number.