Form Approval: OMB No. 0910-xxxx
Expiration Date:
See OMB Statement at end of form

FDA USE ONLY

USE BLUE OR BLACK INK ONLY

DHHS/FDA CANCELLATION OF FOOD FACILITY REGISTRATION FORM

FACILITY REGISTRATION NUMBER:	**PIN:**
O **DOMESTIC REGISTRATION**	O **FOREIGN REGISTRATION**

FACILITY NAME / ADDRESS INFORMATION

FACILITY NAME:	
FACILITY STREET ADDRESS, Line 1:	
FACILITY STREET ADDRESS, Line 2:	
CITY:	**STATE:**
ZIP CODE (POSTAL CODE):	**PROVINCE/TERRITORY:**
COUNTRY:	

CERTIFICATION STATEMENT

The owner, operator, or agent in charge of the facility, or an individual authorized by the owner, operator, or agent in charge 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, operator, or agent in charge of the facility certifies that the above information is true and accurate. An individual (other than the owner, operator, or agent in charge 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 cancellation on the facility's behalf. An individual authorized by the owner, operator, or agent in charge must below identify by name the individual who authorized submission of the cancellation. 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

PRINT NAME OF THE SUBMITTER

CHECK ONE BOX: O A. OWNER, OPERATOR OR AGENT IN CHARGE (STOP HERE, FORM IS COMPLETED)

O B. INDIVIDUAL AUTHORIZED TO SUBMIT THE CANCELLATION (FILL IN BELOW)

IF YOU CHECKED BOX B ABOVE, INDICATE WHO AUTHORIZED YOU TO SUBMIT THE CANCELLATION:

O OWNER, OPERATOR, OR AGENT IN CHARGE (STOP HERE, FORM IS COMPLETED)

O _____ NAME OF INDIVIDUAL WHO AUTHORIZED CANCELLATION ON BEHALF OF OWNER, OPERATOR, OR AGENT IN CHARGE (FILL IN BELOW)

ADDRESS INFORMATION FOR THE AUTHORIZING INDIVIDUAL:

AUTHORIZING INDIVIDUAL ADDRESS, Line 1:	
AUTHORIZING INDIVIDUAL ADDRESS, Line 2:	
CITY:	STATE:
ZIP CODE (POSTAL CODE):	PROVINCE/TERRITORY:
COUNTRY:	PHONE NUMBER (Include Area/Country Code):

FDA USE ONLY

DATE CANCELLATION FORM RECEIVED	**DATE CONFIRMATION SENT TO FACILITY**

MAIL COMPLETED FORM TO U.S. FOOD AND DRUG ADMINISTRATION, HFS-681, 5600 FISHERS LANE, ROCKVILLE, MD 20857, OR FAX IT TO (301) 210-0247.

Public reporting burden for this collection of information is estimated to average 1 hour 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
CFSAN (HFS-024)
5100 Paint Branch Parkway
College Park, MD 20740

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.

Form 3537a (1/03)