

DHHS/FDA – SHELL EGG PRODUCER REGISTRATION FORM

USE BLUE OR BLACK INK ONLY

Date: _____ (MM/DD/YYYY)	
Section 1 - TYPE OF REGISTRATION	
1a. <input type="radio"/> DOMESTIC REGISTRATION	<input type="radio"/> FOREIGN REGISTRATION
1b. <input type="radio"/> INITIAL REGISTRATION <input type="radio"/> UPDATE OF REGISTRATION INFORMATION	<input type="radio"/> NOTIFICATION OF CEASING OPERATIONS AS OF DATE: _____ (MM/DD/YYYY)
1c. If update or ceasing operations notification, provide the following: Facility Registration Number: _____ PIN _____	
1d. If update, check all that apply and further identify changes in the applicable sections.	
<input type="radio"/> Preferred Mailing Address Change	<input type="radio"/> Facility Name Change
<input type="radio"/> Seasonal Facility Dates of Operation Change	<input type="radio"/> Facility Address Change (see instructions)
<input type="radio"/> Operator or Agent in Charge Change	
1e. ARE YOU THE NEW OWNER OF A PREVIOUSLY REGISTERED FACILITY? Yes <input type="radio"/> No <input type="radio"/> If "yes", provide the following information, if known.	
Previous owner's name: _____	Previous owner's registration number: _____
Section 2 - 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: _____	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: _____	
ADDRESS, Line 1: _____	
ADDRESS, Line 2: _____	
CITY: _____	STATE: _____
ZIP CODE (POSTAL CODE): _____	PROVINCE/TERRITORY: _____
COUNTRY: _____	PHONE NUMBER (Include Area/ Country Code): _____

Form Approval: OMB No. 0910-xxxx

Expiration Date:

See OMB Statement at end of form

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FAX NUMBER (Include Area/ Country Code):		E-MAIL ADDRESS:	
Section 4 - 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			
PROVIDE THE FOLLOWING INFORMATION, IF DIFFERENT FROM ALL OTHER SECTIONS ON THE FORM. IF INFORMATION IS THE SAME AS ANOTHER SECTION OF THE FORM, CHECK WHICH SECTION:			
SECTION 2 <input type="radio"/>		SECTION 3 <input type="radio"/>	
STREET ADDRESS, Line 1:			
STREET ADDRESS, Line 2:			
CITY:		STATE:	
ZIP CODE (POSTAL CODE):		PROVINCE/TERRITORY:	
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 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 THE SUBMITTER			
CHECK ONE BOX: <input type="radio"/> A. OWNER OR OPERATOR (STOP HERE, FORM IS COMPLETED)			
<input type="radio"/> B. INDIVIDUAL AUTHORIZED TO SUBMIT THE REGISTRATION (FILL IN BELOW)			
IF YOU CHECKED BOX B ABOVE, INDICATE WHO AUTHORIZED YOU TO SUBMIT THE REGISTRATION:			

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<input type="radio"/> OWNER OR OPERATOR (STOP HERE, FORM IS COMPLETED)	
<input type="radio"/> _____ 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:	
CITY:	STATE:
ZIP CODE (POSTAL CODE):	PROVINCE/TERRITORY:
COUNTRY:	PHONE NUMBER (Include Area/Country Code):
FAX NUMBER (OPTIONAL; Include Area/ Country Code):	E-MAIL ADDRESS (OPTIONAL):

MAIL COMPLETED FDA FORM 3733 TO U.S. FOOD AND DRUG ADMINISTRATION, 10903 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD 20993, OR FAX IT TO (301) 436-2599.

FDA USE ONLY	
DATE REGISTRATION FORM RECEIVED	DATE NOTIFICATION SENT TO FACILITY
CHECK ONE BOX INDICATING FACILITY STATUS:	<input type="radio"/> ACTIVE <input type="radio"/> 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 (HFA-710)
5600 Fishers Lane
Rockville, MD 20857

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.