

Form Approval: OMB No. 0910-0502; Expiration date: 8/31/2016; See OMB Statement below.			
DEPARTMENT OF HEALTH AND HUMAN SERVICES Food and Drug Administration DHHS/FDA CANCELLATION OF FOOD FACILITY REGISTRATION <i>(If entering by hand, use blue or black ink only.)</i>		FDA USE ONLY	
Facility Registration Number: PIN: _____	<input type="checkbox"/> DOMESTIC REGISTRATION	<input type="checkbox"/> FOREIGN REGISTRATION	
FACILITY NAME / ADDRESS INFORMATION			
Facility Name			
Facility Street Address, Line 1			
Facility Street Address, Line 2			
City	State <i>(If applicable; if not, skip to Province/Territory)</i>	Province/Territory <i>(If applicable)</i>	
ZIP or Postal Code	Country		
CERTIFICATION STATEMENT			
<p>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 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.</p>			
Signature of Submitter			
Printed Name of Submitter			
INFORMATION ABOUT INDIVIDUAL SUBMITTING THE CANCELLATION			
Street Address, Line 1			
Street Address, Line 2			
City	State <i>(If applicable; if not, skip to Province/Territory)</i>	Province/Territory <i>(If applicable)</i>	
ZIP or Postal Code	Country		
E-Mail Address <i>(If available)</i>			
Check One Box	<input type="checkbox"/> A. OWNER, OPERATOR OR AGENT IN CHARGE (STOP HERE, FORM IS COMPLETED)	<input type="checkbox"/> B. INDIVIDUAL AUTHORIZED TO SUBMIT THE CANCELLATION (FILL IN BELOW)	
If you checked Box B above, indicate who authorized you to submit the cancellation.			
<input type="checkbox"/> OWNER, OPERATOR OR AGENT IN CHARGE (STOP HERE, FORM IS COMPLETED)			
<input type="checkbox"/> _____ - NAME OF INDIVIDUAL WHO AUTHORIZED CANCELLATION ON BEHALF OF OWNER, OPERATOR, OR AGENT IN CHARGE (FILL IN ADDRESS BELOW)			
Address Information for the Authorizing Individual			
Authorizing Individual Street Address, Line 1			
Authorizing Individual Street Address, Line 2			
City	State <i>(If applicable; if not, skip to Province/Territory)</i>	Province/Territory <i>(If applicable)</i>	

ZIP or Postal Code	Country	Phone Number (Include Area/Country Code)
E-Mail Address (Required unless FDA has granted a waiver under 21 CFR 1.245)		
MAIL COMPLETED FORM FDA 3537a TO U.S. FOOD AND DRUG ADMINISTRATION, FOOD FACILITY REGISTRATION, 5001 CAMPUS DRIVE, HFS-681, COLLEGE PARK, MD 20740 OR FAX IT TO 301-436-2804	FDA USE ONLY Date Registration Form Received Date Notification Sent to Facility	
This section applies only to the requirements of the Paperwork Reduction Act of 1995: The public reporting burden time for this collection of information is estimated to average 1 hour per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the address to the right:	Department of Health and Human Services Food and Drug Administration Office of Chief Information Officer Paperwork Reduction Act (PRA) Staff PRASStaff@fda.hhs.gov	
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FORM FDA 3537a (11/14)		PSC Publishing Services (301) 443-6740 EF