# Change Control Form

**CCF#:** ___________________

**CHANGE REQUEST INITIATION:**

| Originator: | ____________________ |
| Date of Request: | __/__/__ |
| WJHCPOR Equipment Name: | ____________________ |

**CHANGE TYPE:**

| New Requirement: | _____ |
| Design Change: | _____ |
| Upgrade: | _____ |
| Other: | ______________________________________________ |

**REASON/RATIONALE FOR REQUEST:**

**PRIORITY:**

- Emergency: _____
- Urgent: _____
- Routine: _____
- Date Change is Needed: __/__/__

**DESCRIPTION of REQUEST:**

Detail functional and/or technical information. Use attachment if necessary.

**TECHNICAL EVALUATION:** To be completed by Clinical Engineering or designate. Use attachment if necessary.

| Received By: | ____________________ | Date Received: | __/__/__ |
| Assigned To: | ____________________ | Date Assigned: | __/__/__ |

Type of Equipment Affected:

**APPROVALS (circle one):**

- CHANGE APPROVED
- CHANGE NOT APPROVED***

**RATIONALE and TEST CASES:**

**Attachments:** Yes / No

*** Disapproved requests are immediately forwarded to the Designated Approver for archiving.

Changes Made by: ____________________

---

Version 1 (December 1, 2017)  Appendix C: Change Control Form  SOP-TOMRFR-01
Date of Change: ______/____/____ Time of Change (##: ## AM/PM): ________________________

DESCRIPTION of WORK PERFORMED:

TEST RESULTS / IMPACT ASSESSMENT / VALIDATION ACTIVITIES:
(Document any errors and their resolution)

Attachments: Yes / No

Documentation requiring revision has been updated: YES       NO

DESIGNATED APPROVER for CCF PACKAGE: 

CCF Approved: ______       CCF Not Approved: ______

Change Control Log Updated (please circle one): YES       NO

Signature _____________________________________________    Date: ______/____/____

yyyy    mm     dd