Form Approval: OMB No. 0910-0502; Expiration date: 5/31/2010; See OMB Statement below.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

DHHS/FDA CANCELLATION OF FOOD FACILITY REGISTRATION

(If entering by hand, use blue or black ink only.)

FDA USE ONLY

Facility Registration Number: _____

PIN: _____

☐ **DOMESTIC REGISTRATION** ☐ **FOREIGN REGISTRATION**

FACILITY NAME / ADDRESS INFORMATION

Facility Name

Facility Street Address, Line 1

Facility Street Address, Line 2

City	State *(If applicable; if not, skip to Province/Territory)*	Province/Territory *(If applicable)*
ZIP or Postal Code	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 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	Printed Name of Submitter

Check One Box ☐ A. OWNER, OPERATOR OR AGENT IN CHARGE (STOP HERE, FORM IS COMPLETED) ☐ B. INDIVIDUAL AUTHORIZED TO SUBMIT THE CANCELLATION *(FILL IN BELOW)*

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

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

☐ _____ - 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 *(If applicable; if not, skip to Province/Territory)*	Province/Territory *(If applicable)*
ZIP or Postal Code	Country	Phone Number (Include Area/Country Code)

MAIL COMPLETED FORM FDA 3537a TO U.S. FOOD AND DRUG ADMINISTRATION, HFS-681, 5600 FISHERS LANE, ROCKVILLE, MD 20857, OR FAX IT TO 301-436-2804

FDA USE ONLY	
Date Registration Form Received	**Date Notification Sent to Facility**