1. Purpose

This document specifies the procedures to be followed by the PAB and the certification bodies seeking accreditation based on ISO/IEC 17021, ISO/IEC TS 17021-2, ISO/IEC 17021-3 and ISO/TS 22003.

2. Scope

This document provides information on accreditation services by PAB for the applicant and/or accredited management system CBs.

This document includes the procedures for accreditation procedures (application and assessment) and maintenance of accreditation.

This document should be read in conjunction with the relevant international standard, policies and procedures governing the accredited certification body scheme.

3. Responsibility

The Officer-in-Charge/Director, MSA Manager, Program Managers and Accreditation Assessors/Officers, are responsible for the effective implementation of this procedure.

4. Procedure Details

4.1 Accreditation criteria and information

4.1.1 If based in the Philippines, the CB applying for accreditation must be duly registered with the Securities and Exchange Commission, if a corporation or partnership; or with the Department of Trade and Industry if it is a single proprietorship. In case of a foreign applicant CB, a duly notarized registration documents and authenticated by the Philippine Consulate, as proof of being a legal entity, shall be submitted to PAB.

4.1.2 An applicant body shall demonstrate, through assessment of its offices and the witness of its audit process, that it satisfies all the accreditation criteria e.g. PNS ISO/IEC 17021:2011, IAF mandatory and IAF adopted documents, and ISO 19011.

4.1.3 The applicant body shall have granted at least 2 certificates of approval each for ISO 9001 and ISO 14001. It shall agree to continuously comply with the obligations of a CB as stipulated by the PAB.

4.1.4 Upon request, Certification Bodies interested to get accredited by PAB for their certification system can obtain an application package which set out the terms and conditions of accreditation to allow the CB to decide whether it would like to proceed with its application for accreditation or not. The application package includes the following:

a. Application Form (e.g. MSA/SF01 for QMS, EMS, FSMS and HACCP, MSA/SF01-1 for Product Certification)
b. Schedule of fees
c. Procedures for assessment and accreditation (MSA/P01), Complaints(PAB/P09) and Appeals (PAB/P10) and Use of Accreditation Mark (MSA/G01)
d. Accreditation Terms and Conditions
e. Checklist (Certification Scheme Specific)
f. PAB MSA information kit

4.1.5 Any additional explanation needed by the applicant is provided by the MSA Manager/Program Manager including necessary explanations on the specific schemes and scopes of accreditation that are covered under the certification system.

4.2. Application for Accreditation

4.2.1. Application for PAB Accreditation is made by accomplishing the prescribed Application Form, e.g. MSA/SF01, in English and in triplicate copies.

4.2.2. The applicant body shall provide a clear declaration that it agrees to comply with all the accreditation criteria, assessment procedures including the terms and conditions of the certificate of accreditation. This shall be manifested by an authorized signature on the application form.

4.2.3. A CB desiring to be accredited by PAB must submit the following documents along with the prescribed Application Form signed by its representative:

a. Accomplished Checklist of the Accreditation Criteria
b. Copy of SEC Registration with the Articles of Incorporation or DTI Registration or if in case of a foreign CB, duly notarized registration documents and authenticated by Philippine Consulate, as proof of being a legal entity as the case may be.
c. A copy of its Quality Manual and relevant associated documents and records.
d. Documented rules and procedures for Certification activities.
e. Overview of the financial structure of the applicant body
f. Information on fees charged to its applicants and certified suppliers, and the means by which it obtains financial support.
g. Clear definition of the scopes for which accreditation is being sought for.

h. Published certification rules that its applicants must comply with.

4.2.4. The Program Manager reviews and evaluates if the accomplished form and required documents are complete. If there are deficiencies on the documents submitted, the Program Manager informs the applicant in writing and requires them to submit these additional documents.

4.3. The Program Manager evaluates if the MSA has the capability to perform the accreditation service with respect to the scope of accreditation sought by the applicant, the location of the applicant's operations and other special requirements using MSA/SF04 –Resource Review Records.

4.3.1. The Program Manager may arrange a meeting with the applicant if there are some matters which need to be clarified by both sides. The deficiencies observed in its quality manual and associated documents may also be pointed out.

4.3.2. If the application is accepted for further processing, a formal quotation is sent for carrying out the assessment of the applicant body based on the fee schedule. Quotation shall be prepared using MSA/SF02 – Quotation Sheet. In preparing the quotations, the guidelines in Annex B– Determination of man days shall be followed.

4.3.3. For Initial Accreditation, Invoice for the Application Fee will be sent to the Applicant CB. Application Fee is non-refundable.

4.3.4. For CBs that do not require a formal quotation prior to the start of the accreditation process, MSA issues the billing statement when some or all of the accreditation activities have been undertaken. Payment of the fees shall be made prior to the issuance of the accreditation certificate.

4.3.5. Application is valid for one year from the date of the acceptance of application.

5. Preparation for assessment

5.1. Appointment of the assessment team

5.1.1. The Officer-in-Charge/Director or MSA Manager appoints an assessment team, using MSA/SF11 – Assessment Service Request, from the Masterlist of MSA Assessor taking into consideration the approved scopes for assessors.

5.1.2. The number of assessors depends on the number of programs/scopes being applied for accreditation. A one-man team may represent the assessment team provided the required competence to conduct assessment is complied with. When necessary, technical experts in the areas to be assessed may be included in the assessment team as adviser.

5.1.3. The team composition, along with their CV and details of any current affiliations, is transmitted to the applicant for confirmation at least two weeks prior to actual assessment giving them a time to raise any objection against any of the appointment of the assessment team. Any objection by the applicant body must be accompanied in writing with adequate grounds for objection. The MSA Manager will evaluate the objection and decide whether to change the team member or overrule the objection raised by the applicant body. A new team member is nominated from among the list of accreditation assessors.

5.1.4. Each member of the assessment team signs MSA/SF11 – Assessment Service Request which includes the impartiality and confidentiality statement.

5.2. Documentation review

5.2.1 Document Review is carried out for assessments of initial or re-accreditation, However, document review may be also conducted in surveillance when accredited bodies have made any significant changes of quality system.

5.2.2 The Lead Assessor (LA) or the designated Team Leader (TL) undertakes the review of the documents submitted by the applicant CB using the applicable checklist. The LA or TL may delegate the documentation review to a team member.

5.2.3 Results of the review are communicated to the CB. If results show that some requirements of the standards are not being addressed in the quality manual or in other associated documents, the CB shall be required to take corrective actions.

5.2.4 Only when all the issues raised as a result of the documentation review have been addressed and upon the CB's compliance with accreditation requirements based on evaluation of the LA or TL shall the assessment proceed.

5.2.5 In the event that the applicant CB has not acted satisfactorily within six months from the date of the communication of the deficiencies noted during the document review, the processing of the application shall be terminated. However, the CB may still reapply for PAB accreditation.

5.3 Pre-assessment visit

5.3.1 Pre-assessment visit is conducted if the LA or TL finds it necessary or if it is requested by the applicant CB. The appointed assessment team and normally those who conducted the document review carry out the pre-assessment. The management system, quality documentation and its implementation are

discussed during the pre-assessment visit. The assessment team shall exercise due care to avoid consultancy during such activity.

5.3.2 Each member of the assessment team informs the applicant CB of his/her findings that may require corrective actions before the initial assessment can proceed. The LA or TL shall state the status of readiness of the applicant CB for initial assessment. Results of the pre-assessment shall not be used by the applicant to claim that it has been assessed already.

5.4 Conduct of initial assessment

5.4.1 An initial assessment is scheduled by the LA/TL when the non-conformances raised during the documentation review and pre-assessment visit have been corrected.

5.4.2 The initial assessment includes all other premises of the CB from which one or more key activities are performed and which are covered by the scope of accreditation (this is termed as critical locations). The key activities include policy formulation, process and/or procedure development, contract review, planning of conformity assessments, review, approval and decisions on the results of conformity assessments.

5.4.3 The assessment includes office-based (stage 1) and witness audits (stage 2). The witness audit shall cover initial certification or recertification and surveillance by the CB
for its applicant or certified organizations as the case may be. Guidelines for witness audit are given in Annex C.

5.4.4 The date of assessment is communicated to the CB at least two (2) weeks prior to the
actual assessment and shall be agreed by PAB and the CB. The assessment plan is sent to the CB at least one (1) week before the date of assessment.

5.4.5 The assessment team is provided with an assessment kit containing the following but not limited to:

- Accreditation standards e.g. ISO/IEC 17021, ISO 19011, IAF Mandatory documents,
- Copy of applicant's quality manual and associated documents,
- Standard forms e.g. non-conformity report form, assessor's notes, attendance sheet,
- Copy of relevant MSA procedures,
- Assessment plan

5.4.6 The stage 1 assessment is done against the requirements of the relevant standard and IAF mandatory documents. It shall be conducted in accordance with the provisions of ISO 19011 and other relevant MSA requirements.

5.4.7 The assessment starts with an opening meting presided over by the LA/TL, to be participated by the CB's senior management.

5.4.8 During the assessment, the team reviews the policies and procedures of the CB as documented in its quality manual and associated documents. It assesses the implementation of these policies and procedures and the ability of the CB to certify organizations that comply with appropriate management system standards. Where the assessment team cannot reach a conclusion about a finding, the team should refer back to PAB for clarification. Following completion of stage 1, the TL holds a closing meeting.

5.4.9 The witness audit proceeds immediately after the office-based assessment. Whenever possible, both stage 1 and stage 2 audits shall be witnessed for initial certification. The assigned TL prepares a witness audit plan based on the itinerary of the CB's audit team and provide a copy to the team. The services of a technical expert may be engaged, where necessary.

5.4.10 The conduct of opening meeting by the CB's TL, actual audit, audit report preparation, and closing meeting between the CB's team and the organization are assessed against the CB's procedures.

6 Recommendation

6.1 The following definitions shall be taken into consideration when making recommendations:

- Major nonconformity means a significant failure to comply with the PAB accreditation criteria such as lack of documented quality management system, absence of a documented procedure for a fundamental element of the management system and failure to adequately control external personnel.

- Minor nonconformity means those nonconformances which are usually random and unsystematic human errors. This can take place in situation such as when there is a single failure to comply with accreditation criteria or with the CB's documented management system. If a series of minor but related discrepancies are observed which together are judged to be an overall system failure in the area concerned, this shall be considered altogether as a major non-conformity.

- Observation means findings not classified as nonconformity but could be areas for improvement on the operations of the CB. Such observations or areas for improvement should not be interpreted as a form of advice that may lead to consultancy. Corrective actions on observations are not required but will be verified during the next assessment activities. Recurrence of such will be elevated to anonconformity.

6.2 If there are no major nonconformity reports raised, the applicant CB is recommended for accreditation subject to the closed-out of all the minor nonconformity reports raised.

6.3 When there is one or more major nonconformity reports raised, the applicant CB may be subjected to a follow-up visit or reassessment.

6.4 Recommendation for accreditation denial can be made if the following cases are encountered:

- Where competence is not established,
- A major nonconformity was not addressed by the CB,
- Presence of a significant number of minor nonconformities that will prove that the management system of CB is still inadequate.

6.5 Responses to all nonconformities shall be submitted to PAB within 60 days for initial assessment. Nonconformities raised resulting from witness audit shall be responded within one month from the date of the witness audit. All nonconformities shall be cleared within four (4) months from date of on-site assessment. The CB shall ensure that responses and corrective actions take place with sufficient time to provide further responses as required.

6.6 If there is a need to conduct a follow-up visit, the TL or any member of the assessment team conducts the follow-up visit to verify the effectiveness of the corrective actions.

6.7 An extension of one month from the timelines may be extended upon request by the CB. Upon review of the request, PAB may accept or reject such request as appropriate.

6.8 The whole accreditation process is expected to be completed within one year from the date of application. The application may be invalidated if the CB fails to submit within agreed timeframes all corrective actions and other required accreditation related documents. In such case, the CB will have to re-apply and pay application fee.

7 Assessment report

7.1 The TL together with the members prepares a comprehensive final report on the results of the assessment. Prior to the review of the Accreditation Evaluation Panel, PAB sends the final assessment report to the CB for its comments on the contents and to acknowledge the report. The PAB shall remain responsible for the contents of the assessment report, including non-conformities, even if the Team Leader/Lead Assessor or Team Member/assessor is not a permanent staff of the AB. If the report on the outcome of the assessment differs from the report of the findings of the assessment team, PAB shall provide an explanation to the assessed CB.

7.2 The comprehensive final report contains the following as a minimum:

- Names of the members of the assessment team,
- Name and address of the CB,
- Scope/s of the accreditation sought or maintained,
- A description of the accreditation process and criteria including the assessment plan, dates and places of the assessment (stage 1 and stage 2)
- Names of persons and their assigned functions meet in the course of assessment,
- Statement on the adequacy of the CB's systems and procedures to provide confidence in its competence,
- A statement on the compliance of the applicant and/or accredited CB with accreditation criteria and on the actions taken to correct any reported nonconformity/ies,
- Summary of the most important observations, positive as well as negative ones regarding the implementation and effectiveness of the applicant's systems and procedures,
- A recommendation by the assessment team as to granting, reducing, or extending accreditation for the proposed scope,
- Any further information that may assist in determining fulfilment of requirements and the competence of the CB.

7.2 The MSA Manager reviews all the assessment documents and the accreditation file of the CB to check if the accreditation processes have been completed. He/She checks that corrective actions on the nonconformities appear to be sufficient and effective.

7.3 If the MSA Manager is a member of the assessment team, the application package goes to the Program Manager for review prior to submission to the Accreditation Evaluation Panel.

8 Accreditation decision

8.1 An Accreditation Evaluation Panel (AEP) composed of three members is convened to evaluate independently the assessment documents. whether:

- the accreditation processes are complete,
- the assessment is carried out according to established procedures,
- all nonconformities raised are cleared and corrective actions are effective,
- the recommendation of the assessment team is appropriate against the findings.

The evaluation maybe conducted via electronic means

8.2 By signing the Memorandum of appointment issued to the AEP, the members commit their availability to the evaluation and that they have no conflict of interest with the CB under consideration.

8.3 If the AEP finds that items under 8.1 are observed and complete, it confirms the recommendation of the assessment team and endorse the accreditation of the CB to the PAB Director. However, if the AEP observes system incidents by the PAB in processing the accreditation, the Chairman of the AEP informs the Program Manager/TL through the Incident Report. All incident reports shall have been cleared before the recommendation of the assessment team can be confirmed by the AEP.

8.4 If the AEP has some concern over the assessment findings, any of the following conditions can be taken into account, whichever is applicable:

- Extension of the assessment or a special visit to the CB can be requested to clarify and validate some concerns prior to recommendation,
- Increase in the frequency of surveillance visits after accreditation can be made until the performance of the CB is satisfactory and totally acceptable to the AEP.

8.5 The Program Manager prepares a brief summary of the results of the accreditation procedures and submits the summary to the PAB Director for his information and reference in the approval or denial of the certificate of accreditation.

9 Documents from other Accreditation Body

9.1 Where PAB uses the results of an assessment already performed by another accreditation body as a result of the implementation of cross frontier accreditation, same procedure as above follows. Documents from other AB e.g.

document review results, assessment report, non-conformity reports are included in the documents to be submitted to the AEP. PAB considers the reports from the other AB as equivalent and comply with the requirements of ISO/IEC 17011 when the other AB is signatory to IAF/PAC MLA.

10 Issuance of the certificate of accreditation

10.1 The effective date of the Certificate of Accreditation is based on the date of approval by the PAB Director. The Certificate is valid for five years from date of issue.

10.2 The details of the scope of accreditation granted are indicated in an associated document issued together with the terms and conditions of the certificate.

11 Surveillance and reassessment

11.1 After each initial assessment, the TL prepares a surveillance program for each accredited body (MSA/SF08). The program ensures, as a minimum that all elements of the accreditation criteria, approved scopes and where practicable, all branch offices that are covered by scope of accreditation are assessed in a full reassessment cycle.

11.2 First surveillance of the CB after being granted accreditation is conducted within twelve (12) months from date of initial assessment. The second surveillance is conducted at the latest on the twenty-second (22^{nd}) month after the first surveillance assessment. On the second and fourth year of the certificate, the CB is required to submit to PAB the results of its internal audit and management review as part of accreditation monitoring activity.

11.3 Where CB works in different offices, the PAB assesses representative samples of the premises with one or more key activities. PAB ensures that all premises are assessed within the effectivity of its accreditation.

11.4 For each surveillance, as a minimum PAB will look into the following:

- Effectiveness of the accredited CB's operation with regards to achieving the objectives of ISO/IEC 17021;
- Results of management review and internal quality audit
- Customer complaints, records of investigation and corrective action taken
- Changes to the documented system;
- Action taken on nonconformities identified during the last surveillance assessment
- Progress of planned activities aimed at continual improvement of operational performance

11.5 Any member of the team who conducted the initial assessment may be among those who shall conduct the first surveillance. The processes for surveillance assessment follow those of the initial assessment including planning and selection of assessment team.

11.6 Surveillance assessment shall cover both the office-based and witness audits of the selected accredited scope as per Annex 2. The time frame to correct all nonconformities raised during surveillance assessment depends upon the nature of the non-conformance.

11.7 When a nonconformity has been classified as minor, the CB has 30 days to submit corrective action. On the basis of the evidences of the implementation of the corrective action, the minor nonconformity may be closed-out or followed up during next visit, i.e. closure will be done on the next visit if the evidences of the implementation of the corrective action are not sufficient. The assessment team may recommend the continued accreditation upon submission of the corrective actions.

11.8 In case however, a major nonconformity has been raised and the necessary corrective action to be implemented requires significant changes, the accredited CB shall have seven (7) working days to respond to the nonconformity citing the proposed corrective actions. The nonconformity may be closed-out by on-site verification or an off-site review of documentary evidences of corrective actions. The evaluation of the evidences of corrective actions shall take place within three (3) months from the date of surveillance assessment.

11.9 In case the CB fails to clear all the nonconformities within the prescribed time frame, the TL is obliged to make recommendation for suspension to the AEP pending implementation by the CB of appropriate corrective action. Moreover, failure by the CB to implement corrective action within six (6) months shall result in the TL being obliged to recommend withdrawal of the Certificate of Accreditation.

11.10 Where an assessment finding has been detected as repetitive in nature and such finding has not been adequately addressed, the assessment team may elevate such finding to either minor or major nonconformity, whichever is applicable.

11.11 Special surveillance assessment shall be conducted should the AEP or the PAB Director deems it necessary. The following are examples where the surveillance program may be modified to include more frequent visits if:

- There are reasons to suspect that performance of the accredited CB may have deteriorated; or

- The accredited CB undergoes a significant re-organization e.g. change in legal, commercial, ownership, top management and key personnel; or
- Changes in main policies, scope of accreditation; or
- Adequate review of a particular area during the previous visit has not been possible; or
- The accredited CB engages a significant number of new auditors since the last assessment; or
- Based on complaints against the accredited CB.

The PAB shall inform the CB of the possibility of the special surveillance assessment.

11.12 The special surveillance activity may either be increased or relaxed as a result of the level of confidence.

12 Reassessment

12.1 PAB shall start the reassessment process of accredited CB six (6) months prior to the expiration of the validity of the certificate. This is to ensure that the CB remains accredited while the reassessment process is in progress.

12.2 If the accredited CB applies for re-accreditation, it will be subjected to a reassessment equivalent to an initial assessment. In case the accredited CB does not re-apply, the procedure for suspension, cancellation and withdrawal may be followed until re-assessment is finally completed.

12.3 On-site assessment includes all other premises of the CB from which one or more key activities are performed and which are covered by the scope of accreditation.

12.4 Records generated during the five year operation as accredited CB shall be assessed also.

12.5 The re-accreditation of the CB may be granted even when the witness audits have not been completed on expiry date of the certificate on condition that there is no major nonconformity in the office-based assessment and in the witness audits already conducted.

13 Scope extension/reduction

13.1 When an accredited CB decides to apply for scope extension, an application for extension is filed using MSA/SF01. Application for extension is limited to a maximum of ten (10) scopes. Upon filing, there is a corresponding application fee

which can be included in the billing when the assessment activities are completed.

13.2 The accredited CB shall submit procedures related to the scopes and qualifications of its certification personnel.

13.3 Assessment is carried out as part of the surveillance visit or re-accreditation assessment. Selection of scopes for witness audits follows the guidelines in Annex 2. The expiry date of the additional accredited scope/s shall be identical to the expiry date of the original certificate of accreditation. The associated document to the Certificate of Accreditation is revised to include the extended scope/s. The original certificate of accreditation issued to the CB remains the same.

13.4 PAB may decide to reduce the scope of accreditation to exclude those parts where the CB has persistently failed to meet the requirements for accreditation including competence.

13.5 If for some reasons the accredited CB decides to reduce the scopes of its accreditation, it shall write the PAB Director of its decision. The CB shall discontinue the use of all advertising materials that refer to the original approved scopes.

13.6 Final review of the recommendation for extension or reduction of scopes shall be done by the AEP if the assessment is carried out as part of the reassessment or by a PAB Accreditation Staff if the assessment is carried out as part of surveillance assessment.

14 Suspension and withdrawal of accreditation

14.1 The PAB shall suspend the certificate of accreditation granted to a CB in cases of the following:

- Unjustified refusal of the accredited CB to allow PAB assessors access to its premises, facilities, records, and personnel, as may be necessary, for the conduct of surveillance visits during working hours;
- Use of the Certificate of Accreditation beyond its scope;
- Violation of the non-transferability condition of the Certificate of accreditation;
- Failure of the accredited CB to observe PAB rules on the use of the accreditation mark;
- Failure of the accredited CB to address within the agreed time frame any nonconformities found;
- The accredited CB has made changes in its management system that is not acceptable to PAB;

- Failure of the accredited CB to pay the required fees;
- Failure of the accredited CB to observe any of the terms and conditions of the certificate of accreditation.

14.2 The period of suspension shall be up to six (6) months depending on the gravity of offense. However, failure of the accredited CB to undertake appropriate corrective actions within the suspension period shall result in the withdrawal of the Certificate of Accreditation.

14.3 The PAB shall withdraw the Certificate of Accreditation in cases of the following:

- Wilful misrepresentation/s by the accredited CB of a material fact in obtaining the Certificate of Accreditation;
- Failure of the accredited CB to continuously conform to the accreditation criteria;
- If the accreditation criteria are changed and the accredited CB fails to ensure conformity despite stern warning, with the new requirements;
- When the CB request its withdrawal;
- When the PAB ceases to operate its accreditation scheme.

14.4 The AEP shall review and evaluate the recommendation of the assessment team to suspend or withdraw the accreditation of a CB. The PAB Director finally decides on the recommendation of the AEP.

14.5 The suspension or withdrawal of a certificate of accreditation shall be published by the PAB.

15 Appeals and Complaints

15.1 Any appeal or complaint received by PAB is addressed in procedure PAB/P09 or PAB/P10 which is publicly available.

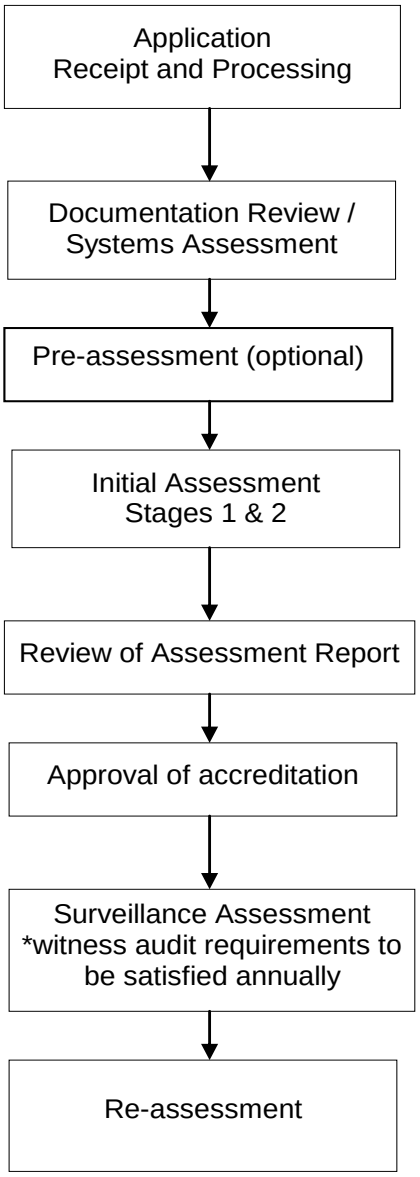
16 Records

16.1 MSA/SF01 – Application Form
16.2 MSA/SF02 – Quotation Sheet
16.3 MSA/SF03 – Job Sheet
16.4 MSA/SF04 – Resource Review Records
16.5 MSA/SF05 – Assessment Findings
16.6 MSA/SF05A – Witness Audit Report
16.7 MSA/SF05B – Witness Audit Report Stage 1
16.8 MSA/SF07 – Assessment Review Report
16.9 MSA/SF08 – Surveillance Program
16.10 MSA/SF10 – Statement of Confidentiality

16.11 MSA/SF11 – Assessment service request
16.12 MSA/SF13 – Assessment Notes
16.13 MSA/SF14 – Attendance Sheet
16.14 MSA/SF15 – Final Assessment Report
16.15 MSA/SF16 – Assessment Plan Stage 1
16.16 MSA/SF17 – Assessment Plan Stage 2
16.17 MSA/SF18 – Briefing and orientation record
16.18 MSA/SF20 – Memorandum to AEP
16.19 MSA/SF23 – Accreditation Evaluation Report

Annex A

Accreditation Process Flow Chart



Formal Application, together with its quality documentation, is received from an applicant CB.

The CB submits its quality documentation for a systems review.againsts relevant standards

An applicant can request for a pre-assessment to be conducted.

PAB MSA carries out assessment in two stages to determine compliance with the accreditation criteria
Stage 1 – Office based assessment
Stage 2 – Witness of the CB's audit

The assessment report is endorsed to an impartiall and independent Accreditation Evaluation Panel for review who will then make a recommendation.

PAB Director makes final decision on accreditation upon recommendation of the AEP. When granted, Certificate is valid for 5 years.

Accredited CB will be subjected to surveillance assessments to ensure the ACB's continued compliance with the terms and conditions of the Certificate of Accreditation.

A full reassessment of the ACB's management system is done every five (5) years.

Office-Based Assessment to be conducted atleast six (6) months prior to expiry.

Annex B

Guidelines for Determination of Accreditation Assessment Man-Days

1 Calculation of man-days during office based assessment shall be based on the following:

- types of assessment e.g. initial, surveillance, or reassessment;
- number of scopes being applied;
- number of management systems certification programs e.g. QMS, EMS, HACCP, FSMS;
- number of certificates issued;
- number of critical locations;
- Prior knowledge of CB's management system;
- Client's preparedness for accreditation;
- Maturity of management system;
- Number of nonconformities and corrective actions to be followed-up;

2 The standard man-days are as follows:

Certification Programs (QMS , EMS, FSMS, ISMS)	Initial	Surveillance	Reassessment
One	4	2	3
Two	5	3	4
Three	6	4	5
Four	7	5	6

3 Depending on the applicable factors above, the number of man-days maybe increased or decreased.

4 The standard man-days for document review for one management system is two (2). An additional of one man-day is estimated for one more management system.

5 The number of man-days for post assessment activities e.g. report writing and review of corrective actions is estimated as two (2) man-days.

6 Whenever possible, the number of man-days for witness audit shall follow the audit man-days of the certification body.

Annex C

Guidance for witness audit

1 Scope

1.1 This guidance document describes the process of conducting the witness audit for the initial / reassessment and surveillance assessment of the CABs conducting management systems certification.

1.2 The number and type of organizations to be subject for witness audit shall be based on :

- the category of scope under which the organization belongs
- the type of CB audit to the organization
- the type of AB assessment to the CB

2 Definitions

2.1 For the purpose of this guidance document, the following definitions shall apply.

NACE Code – Statistical nomenclature for economic activities rev.2, published by the Commission of European Communities

General Scope – The activities of the organization are considered to have less level of complexity in process; have a fundamental technology, and do not require additional special skills/expertise for operation. These activities are likely to have less level of environmental impact and risk.

Critical Scope – The activities of the organization are considered to have high level of complexity in process; have an advanced technology, and require additional special skills/expertise for operation. These activities are likely to have high level of environmental impact and risk.

3 Accreditation scope

3.1 The accreditation scope, both for QMS and EMS accreditation scheme with reference to NACE Code shall be divided into 2 categories, which are the general and critical scopes as detailed in Table 1 (for QMS) and Table 2 (for EMS) respectively.

3.2 The accreditation scope for FSMS / HACCP shall follow Table A.1 of ISO/TS 2003:2007.

4 Guidance

4.1 The witnessing of CAB audits on its clients is valuable for:

- Verifying, on site, the effectiveness of a CAB's programmes and procedures and especially with regard to its assignment of a competent audit teams.
- Observing the CAB's auditors, as they perform a certification, a re-certification, or a surveillance audit, to evaluate if they :
    - comply with the CAB's procedures,
    - comply with ISO 19011
    - have the required expertise of the sector in which the audit is being undertaken
    - undertake the audit effectively

4.2 The witnessing enables PAB to determine whether the CAB is effective in controlling its decision making and certification processes, and thus to assess the CAB's capability to perform accredited certification.

4.3 To ensure that the required number of witness audits is completed on time (i.e. within the surveillance and re-assessment period) the accredited Certification Body shall submit to PAB every January of each year, a list of organizations to be audited for the next 12 month period. Note: Witness audits maybe done before the office-based scheduled assessment.

4.4 Prior to witnessing, the CAB shall provide PAB of the following documents for review and evaluation purposes:

- Agreement between the CAB and its client allowing PAB to join the audit. The agreement should ensure that the PAB has the right to witness CAB audits.
- Copy of the CAB audit plan;
- Background information on the CAB's audit team;
- Copy of the quality manual and key procedures of its client to be audited;
- If the audit being witnessed is an initial certification / reassessment, a copy of the document review report and/or stage 1 audit report;
- Audit report, required actions and responses from the previous audit activity.

4.5 The number of witness audits shall be in accordance with the following:

4.5.1 Organization scheduled for initial or recertification by the accredited CAB is considered to be the first priority for witness audit. However, if this policy will cause unnecessary delays to the accreditation process, two surveillance audits may be witnessed as an alternative which include element 7, product realization

of ISO 9001:2008 and element 4.4.6, operational control of ISO 14001 as part of the audit.

a. General Scope – 10% of the general scopes that the CB applied for accreditation rounded off to the nearest higher whole number shall be subjected to witness audits. Whenever possible, PAB shall witness both the stage 1 and stage 2 certification or recertification audits of the CAB of its client.

b. Critical Scope – 50% of the critical scopes that the CB applied for accreditation shall be subjected to witness audits. PAB shall witness both the stage 1 and stage 2 certification or recertification audits of the CAB of its client.

4.5.2 For Surveillance Assessment

a. General Scope – The number of witness audit shall be 1 scope per year for the four year surveillance period.

b. Critical Scope – The number of witness audit shall be 1 scope per year for the four year surveillance period.

4.5.3 For Accreditation Reassessment

a. General Scope - Same as for initial assessment.

b. Critical Scope – 25% of the critical scopes that the CB applied for re-accreditation shall be subjected to witness audits, rounded to the nearest higher whole number. Whenever possible, PAB shall witness both the stage 1 and stage 2 certification or re-certification audits of the CAB of its client.

4.6 Whenever possible, during the whole accreditation cycle, no CB auditor and scope shall be witnessed twice.

4.7 During the office-based assessment, the PAB assessment team and the CAB shall agree on the schedule, the organizations and the scopes that will be subject to witness audits.

4.8 Accredited CABs and their clients should be aware that failure to conduct the agreed witness audits shall be a ground for raising a non-conformity.

4.9 The whole level 2 scope shall be granted after the CAB is found competent to carry out conformity assessment based on the witness audit conducted by the assessment team following the above procedure.

TABLE 1 QMS Classification of Accreditation Scope

GENERAL SCOPE	CRITICAL SCOPE
IAF 1	IAF 2
IAF 4	IAF 3
IAF 6	IAF 5
IAF 7	IAF 9
IAF 8	IAF 10
IAF 14	IAF 11
IAF 15	IAF 12
IAF 17	IAF 13
IAF 23	IAF 16
IAF 29	IAF 18
IAF 30	IAF 19
IAF 31	IAF 22
IAF 32	IAF 24
IAF 34	IAF 25
IAF 35	IAF 26
IAF 39	IAF 27
	IAF 28
	IAF 33
	IAF 36
	IAF 37
	IAF 38

TABLE 2 EMS Classification of Accreditation Scope

GENERAL SCOPE	CRITICAL SCOPE
IAF 6	IAF 1
IAF 7	IAF 2
IAF 8	IAF 3
IAF 14	IAF 4
IAF 17	IAF 5
IAF 18	IAF 9
IAF 19	IAF 10
IAF 22	IAF 11
IAF 23	IAF 12
IAF 30	IAF 13
IAF 31	IAF 15
IAF 32	IAF 16
IAF 33	IAF 24
IAF 34	IAF 25
IAF 36	IAF 26
IAF 37	IAF 27
	IAF 28
	IAF 29
	IAF 35
	IAF 38
	IAF 39 (limited to NACE 37,38.1,38.2,39)

PAB does not accredit the scope IAF 20 (shipbuilding) and IAF 21 (Aerospace) both for QMS and EMS accreditation scheme.

17 Revision History

Title	Issue	Revision	Effectivity Date	Amendments
MSA/P01 – The Accreditation Process	1	0	March 2015	Initial Issue
MSA/P01 – The Accreditation Process	1	1	May 2015	Alignment to IAF Coding for the Classification of Accreditation of Scope
MSA/P01 – The Accreditation Process	1	2	December 2015	Addition of provision on the submission of list of organization to be audited by an accredited CB for the whole year/ 12 month period on Annex C