



Business Quality Assurance International

BQA Operations Administration
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QUESTIONNAIRE FORM

Your Business Information

Business Name:

Address:	Phone:
	Fax:
	Email

Brief Description of Business:
(Including Main Products or Services)

If Part of Group, Parent Organisation:

Single or Multi-Site:
(Including Project Sites)

Number of Employees by Location:

Business Hours: <i>(Office & Product/Service)</i>	9 to 5 <i>(Office)</i>	Other <i>(Office)</i>	24/5 <i>(Product)</i>	24/6 <i>(Product)</i>	24/7 <i>(Product)</i>
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Number of Shifts:

Current Management System: <i>(If Any)</i>	QMS	EMS	OH&S	Other
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Details of any Trade Associations:
(Business Membership)

Details of any outsourced processes:

Do you have a consultancy involved in your Management System?:

Your Business Requirements

ISO Certification:	QMS	EMS	OH&S	Other
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Required by Date:

Initial Visit incl. preparation (Stage 1):	QMS	EMS	OH&S	Other
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Date of Preliminary (Stage 1) Visit:

Other Industry Certification:

For BQA Operations Administration Use

Form Received Date		Information Sent Date		Database Updated	
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