



# National Accreditation Board for Testing and Calibration Laboratories (NABL)

## Assessment Forms and Checklist (based on ISO/IEC 17043: 2010)

ISSUE NO.: 03  
ISSUE DATE: 16-Feb-2021

AMENDMENT NO.: --  
AMENDMENT DATE: --

## AMENDMENT SHEET

| S. No. | Page No. | Clause No. | Date of Amendment | Amendment | Reasons | Signature<br>QA Team | Signature CEO |
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| National Accreditation Board for Testing and Calibration Laboratories |                                                               |                |                 |                   |
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| Doc. No.: NABL 183                                                    | Assessment Forms and Checklist (Based on ISO/IEC 17043: 2010) |                |                 |                   |
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## ASSESSMENT SCHEDULE

|                                                                                                             |                                                                             |                                                 |                                                                 |           |
|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------|-----------|
| <b>Name of the PT Provider:</b>                                                                             |                                                                             | <b>Location(s):</b>                             |                                                                 |           |
| <b>Person responsible for Proficiency Testing Activities (PT Co-ordinator):</b>                             |                                                                             |                                                 |                                                                 |           |
| <b>Date of Assessment:</b>                                                                                  |                                                                             | <b>Site (s):</b> PT provider /<br>Subcontractor |                                                                 |           |
| <b>Type of Visit:</b> Assessment / On-site Surveillance / Re-Assessment / Supplementary Visit               |                                                                             |                                                 |                                                                 |           |
| <b>Discipline:</b> Testing/ Calibration/ Medical/ Inspection                                                |                                                                             | <b>Sub-discipline:</b>                          |                                                                 |           |
| <b>Assessment Standard:</b> ISO / IEC 17043: 2010<br><b>Specific Criteria of NABL:</b>                      |                                                                             |                                                 |                                                                 |           |
|                                                                                                             |                                                                             |                                                 |                                                                 |           |
| <b>Assessment Timings</b>                                                                                   |                                                                             | <b>Opening/Closing Meeting</b> Date/Time        | <b>Daily Debriefing</b> Date / Time<br>(at the end of each day) |           |
| Morning: AM to PM<br>Afternoon: PM to PM                                                                    |                                                                             | Opening Meeting:<br>Closing Meeting:            | Day 1:<br>Day 2:                                                |           |
|                                                                                                             |                                                                             |                                                 |                                                                 |           |
| <b>Name and Expertise of the Assessor</b>                                                                   | <b>Schedule of Department/ Section/ Activity to be Assessed (date wise)</b> |                                                 |                                                                 |           |
|                                                                                                             | Day 1                                                                       |                                                 | Day 2                                                           |           |
|                                                                                                             | Morning                                                                     | Afternoon                                       | Morning                                                         | Afternoon |
| <b>Lead Assessor</b>                                                                                        |                                                                             |                                                 |                                                                 |           |
| <b>Assessor 1</b>                                                                                           |                                                                             |                                                 |                                                                 |           |
| <b>Assessor 2</b>                                                                                           |                                                                             |                                                 |                                                                 |           |
| <b>Assessor 3</b>                                                                                           |                                                                             |                                                 |                                                                 |           |
| <b>Assessor 4</b>                                                                                           |                                                                             |                                                 |                                                                 |           |
| <b>Assessor 5</b>                                                                                           |                                                                             |                                                 |                                                                 |           |
| <b>Observer</b><br>(only for observation)                                                                   |                                                                             |                                                 |                                                                 |           |
| I declare that the assessment schedule has been prepared after discussing with the assessment team members. |                                                                             |                                                 |                                                                 |           |
| Signature of Lead Assessor                                                                                  |                                                                             |                                                 |                                                                 |           |

| National Accreditation Board for Testing and Calibration Laboratories |                                                               |                |                 |                   |
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[illegible]

## ASSESSOR'S OBSERVATIONS

[illegible]

|                                                                              |                                                               |                |                 |                   |
|------------------------------------------------------------------------------|---------------------------------------------------------------|----------------|-----------------|-------------------|
| <b>National Accreditation Board for Testing and Calibration Laboratories</b> |                                                               |                |                 |                   |
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**PT SCHEME(S) VERIFIED BY THE ASSESSMENT TEAM**

(To be filled in by each Technical Assessor/Expert)

[illegible]

|                                                                              |                                                               |                |                 |                   |
|------------------------------------------------------------------------------|---------------------------------------------------------------|----------------|-----------------|-------------------|
| <b>National Accreditation Board for Testing and Calibration Laboratories</b> |                                                               |                |                 |                   |
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**ASSESSOR'S SUMMARY ON NON-CONFORMITY**

(Please use separate sheet for raising each Non-Conformity)

|                                                                                                                  |                   |                              |  |
|------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------|--|
| <b>Name of the PT Provider:</b>                                                                                  |                   |                              |  |
| <b>Name of the Assessor</b>                                                                                      |                   |                              |  |
| <b>Date of Assessment:</b>                                                                                       | <b>PT Scheme:</b> | <b>Activity Assessed:</b>    |  |
| <b>NC No.</b>                                                                                                    |                   |                              |  |
| <b>Non-Conformity Statement:</b>                                                                                 |                   |                              |  |
|                                                                                                                  |                   |                              |  |
| <b>Cl. No. of ISO 17034: 2016 &amp; NABL 133 Clause No. / NABL Specific criteria:</b>                            |                   |                              |  |
|                                                                                                                  |                   |                              |  |
| Signature & Name of PT provider Representative                                                                   |                   | Signature & Name of Assessor |  |
| <b>CORRECTION PROPOSED BY THE PTP</b>                                                                            |                   |                              |  |
|                                                                                                                  |                   |                              |  |
| Signature of PT Provider Representative                                                                          |                   |                              |  |
| <b>ASSESSOR'S COMMENTS ON CORRECTION ACTION PROPOSED BY THE LABORATORY:</b>                                      |                   |                              |  |
| <b>(PTP to provide corrective action and root cause analysis along with the evidences of corrective actions)</b> |                   |                              |  |
|                                                                                                                  |                   |                              |  |
| Signature of Assessor                                                                                            |                   |                              |  |
| <b>LEAD ASSESSOR'S REMARKS ON NON-CONFORMITY, IF ANY:</b>                                                        |                   |                              |  |
|                                                                                                                  |                   |                              |  |
| Signature & Name of Lead Assessor                                                                                |                   |                              |  |

| National Accreditation Board for Testing and Calibration Laboratories |                                                               |                |                 |                   |
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## SUMMARY OF THE ASSESSMENT

| Sl.                                                                | Item                                                                                                                                                | Details                                                                                                                                                                                                                                         |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|----------|---------------|----------------------------------|------------|---------|-------------|-----------------------------------------|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|--|--|
| 1.                                                                 | Name of the PT Provider                                                                                                                             |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 2.                                                                 | Person responsible for Proficiency Testing Activities (PT Co-ordinator):                                                                            |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 3.                                                                 | Date of Assessment                                                                                                                                  |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            | Field:  | PTP         |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 4.                                                                 | Discipline(s)                                                                                                                                       | Testing/Calibration/Medical/Inspection                                                                                                                                                                                                          |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 5.                                                                 | Facility                                                                                                                                            | Permanent/ Site/ Mobile                                                                                                                                                                                                                         |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 6.                                                                 | Type of Assessment                                                                                                                                  | Final Assessment/ Onsite Surveillance/ Re-assessment / Supplementary visit                                                                                                                                                                      |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 7.                                                                 | Assessment Team                                                                                                                                     | <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
|                                                                    |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
|                                                                    |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
|                                                                    |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 8.                                                                 | Date of earlier visit                                                                                                                               | Non-Conformities during earlier visit have/ have not been discharged. (Yes or No)                                                                                                                                                               |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 9.                                                                 | Total no. of Non-conformities                                                                                                                       | <table border="1"> <tr> <td></td> <td colspan="11">Number of NC(s)</td> </tr> <tr> <td>Clause 4</td> <td colspan="11"></td> </tr> <tr> <td>Clause 5</td> <td colspan="11"></td> </tr> <tr> <td>Total</td> <td colspan="11"></td> </tr> </table> |          |          |          |          |               |                                  |            |         |             |                                         |  |  | Number of NC(s) |  |  |  |  |  |  |  |  |  |  | Clause 4 |  |  |  |  |  |  |  |  |  |  |  | Clause 5 |  |  |  |  |  |  |  |  |  |  |  | Total |  |  |  |  |  |  |  |  |  |  |  |
|                                                                    | Number of NC(s)                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| Clause 4                                                           |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| Clause 5                                                           |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| Total                                                              |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 10.                                                                | Comment(s) of Assessment Team on compliance of laboratory to:                                                                                       | NABL 133*<br>NABL 142*<br>Specific Criteria*<br><i>*(Lead Assessor to comment on the basis of observations of Technical Assessor(s))</i>                                                                                                        |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 11.                                                                | Assessment Summary                                                                                                                                  |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 12.                                                                | Recommendation of Assessment team as per ISO 17043: 2010                                                                                            |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 13.                                                                | Only if accreditation is recommended, date by which the Corrective Action to be submitted by the PTP for the above Non-conformities (Max. 30 days): |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 14.                                                                | The requirements of NABL 133 have been explained by the Lead Assessor and understood by the PTP                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               |                                  |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| Enclosures                                                         | NAF PT 6                                                                                                                                            | NAF PT 5                                                                                                                                                                                                                                        | NAF PT 4 | NAF PT 3 | NAF PT 2 | NAF PT 1 | Check list PT | Form PT 72                       | Form PT 74 | Form 45 | TA/DA Forms | Any other supporting documents/ records |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
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| Acknowledgement by Authorised Representative of PT Provider & Date |                                                                                                                                                     |                                                                                                                                                                                                                                                 |          |          |          |          |               | Signature of Lead Assessor& Date |            |         |             |                                         |  |  |                 |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |

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## RECOMMENDED SCOPE OF ACCREDITATION

| Name of the PT Provider:                                           |                    |                                                     |                                                                                          | Date of Assessment                   |                       |                                                                                                                                     |
|--------------------------------------------------------------------|--------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Discipline:                                                        |                    | Sub-disciplines:                                    |                                                                                          | Location(s):                         |                       |                                                                                                                                     |
| S. No.                                                             | Type of PT Scheme* | Proficiency Testing Scheme/ Type of PT Item/ Matrix | Measurand/ Characteristic/ Type of measurand/ Type of characteristic/ Analyte/ Parameter | Range of Measurement (if applicable) | Periodicity (Minimum) | Assessment Technique used by Assessor(s)<br><small>(Witness / Document review / Interviewing / File Review (Record Review))</small> |
|                                                                    |                    |                                                     |                                                                                          |                                      |                       |                                                                                                                                     |
| *Refer to ISO/IEC 17043:2010 Cl. 3.7 for selecting type of Scheme. |                    |                                                     |                                                                                          |                                      |                       |                                                                                                                                     |
| Signature & Name of authorized Representative of PT provider       |                    | Signature & Name of Assessor(s)                     |                                                                                          | Signature & Name of Lead Assessor    |                       |                                                                                                                                     |

| National Accreditation Board for Testing and Calibration Laboratories |                                                               |                |                 |                   |
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**DECLARATION OF IMPARTIALITY & CONFIDENTIALITY**  
(to be filled in by each Assessor and enclosed with the Assessment report)

|                           |                                                                                                             |                                                 |
|---------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <b>Name</b>               |                                                                                                             | Assessor ID:<br>(To be filled in by NABL Sect.) |
| <b>Designation</b>        |                                                                                                             |                                                 |
| <b>Organisation</b>       |                                                                                                             |                                                 |
| <b>Address</b>            |                                                                                                             |                                                 |
| <b>Capacity</b>           | Lead Assessor / Technical Assessor / Technical Expert / Observer                                            |                                                 |
| <b>CAB* Assessed</b>      |                                                                                                             |                                                 |
| <b>Date of Assessment</b> |                                                                                                             |                                                 |
| <b>Type of Assessment</b> | QM Adequacy / Pre-Assessment / Final assessment / Onsite Surveillance / Re-Assessment / Supplementary visit |                                                 |

\*CAB – Conformity Assessment Body (Testing / Medical / Calibration laboratory / Proficiency Testing Provider (PTP) / Reference Material Producer (RMP))

I \_\_\_\_\_, hereby declare that I have not offered any consultancy, guidance, supervision or other services to the CAB (e.g. internal audit), in any way.

I am / am not\* an ex-employee of the CAB and am/ am not\* related to any person of the management of the CAB.

I got an opportunity to go through various documents like Quality Manual, Procedural Manuals, Work instructions, Internal reports etc. of the above CAB and other related information that might have been given by NABL. I undertake to maintain strict confidentiality of the information acquired in course of discharge of my responsibility and shall not disclose to any person other than that required by NABL.

\*Strike out which is not applicable

Date:

Place :

Signature

| National Accreditation Board for Testing and Calibration Laboratories |                                                               |                |                 |                    |
|-----------------------------------------------------------------------|---------------------------------------------------------------|----------------|-----------------|--------------------|
| Doc. No.: NABL 183                                                    | Assessment Forms and Checklist (Based on ISO/IEC 17043: 2010) |                |                 |                    |
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# ASSESSOR CHECKLIST – BY LEAD ASSESSOR/TECHNICAL ASSESSOR

(To be filled in by the Assessor)

## Checklist 1 – By Lead Assessor/Technical Assessors/ Experts

The following pages present a checklist of the criteria from ISO/IEC 17043: 2010, which is the basis for the NABL General requirements for proficiency testing. The PT provider's policies and procedures must meet full requirements of ISO/IEC 17043: 2010. **The actual standard must be referred for the definitive language and interpretation.**

#The Assessment team must complete this checklist, put initials on each page. The following symbols may be used for completing this checklist.

|         |                        |
|---------|------------------------|
| ++ =    | COMPLIANCE             |
| + =     | COMPLIANCE WITH REMARK |
| A =     | MAJOR NON-COMPLIANCE   |
| B =     | MINOR NON-COMPLIANCE   |
| NA =    | NOT APPLICABLE         |
| BLANK = | NOT ASSESSED           |

The Lead Assessor / Assessor(s) must review the PT provider's documented system and verify compliance with the requirements of ISO/IEC 17043:2010 is indeed implemented as described, record in OBSERVATION/CONCLUSION related to any requirements on the space provided or use the bottom of the page or use separate sheet(s). All non-conformity(ies) must be identified and reported separately on each sheet of NAF PT-4. This checklist be submitted as a part of the assessment report.

|                                                |  |
|------------------------------------------------|--|
| PT PROVIDER ASSESSED                           |  |
| CITY/TOWN                                      |  |
| ASSESSMENT DATE (S)                            |  |
| NAME OF THE ASSESSOR /<br>CAPACITY IN THE TEAM |  |
| SIGNATURE                                      |  |

#-Applicable for Offline Assessments

Assessor shall enter comment in "REMARK" box for each sub clause.

| National Accreditation Board for Testing and Calibration Laboratories |                                                               |                |                 |                    |
|-----------------------------------------------------------------------|---------------------------------------------------------------|----------------|-----------------|--------------------|
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