

PROCEDURE MANUAL 01:

Control of Documents & Records



Republic of the Philippines
Laguna State Polytechnic University
Province of Laguna





Republic of the Philippines

Laguna State Polytechnic University

PROCEDURE MANUAL 01: Control of Documents and Records

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Date:

Alfonso
Oct. 3, 2019

1.0 Objective

To establish proper flow, handling and control of essential documents and records affecting the quality products/service of the Quality Management System of Laguna State Polytechnic University.

2.0 Scope

This procedure covers all documents that will be subjected for initiation, review, approval, issuance, revision, control and maintenance such as quality manual, procedure manuals, work instructions, syllabus, operations manual, applicable statutory and regulatory requirements, international standards and applicable records.

3.0 Reference Documents

| | |
|---------------|--|
| ISO 9001:2018 | : Quality Management System Requirements |
| LSPU-QM | : Quality Manual |
| LSPU-PM-02 | : Internal Quality Audit |
| LSPU-PM-03 | : Control of Non Conformity, Corrective Action |
| RA 9470 | : NAP General Circular No.1, Jan. 20, 2009; National Archives of the Phil. Act of 2007 |
| RA 10173 | : Data Privacy Act 2012 |

All Work Instructions, Standard Operating Procedures (SOPs) and records as required by the international standards

4.0 Procedure

4.1 Identification and Control of Documents and Records

Each document shall have a unique document identification title, control number and revision number such as:

Quality Manual, LSPU - QM
University Name - Quality Manual

Procedure Manual, LSPU - PM - XX
University Name - Procedure Manual - Control #

Work Instruction, LSPU - YYYY - WI - XXX
University Name - Dept./Sect - Work Instruction - Control #

Forms, LSPU - YYYY - SF - XXX
University Name - Dept./Sect - System Forms - Control #

Log Book, LSPU - YYYY - LB - XXX
University Name - Dept. Sec. Log book - Control #

Memorandum, LSPU-YYYY-MO-XXX
University Name-Dept./Unit- Memorandum- Control #

Request Letter, LSPU- YYYY- RL-XXX
University Name- Dept./Unit- Request Letter-Control #

Revision, Rev. 0, 1, 2, 3...

4.2 Review, Approval and Issuance

- 4.2.1 Upon initiation of a new procedure and form, the originating department heads/associate deans shall prepare the document and the respective Vice-President shall likewise conduct review for adequacy and suitability. Approval is by the University President.
- 4.2.2 For Quality Manual, all the Vice Presidents shall conduct final review and shall be approved by the University President.



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For Procedure Manual to wit:

- Control of Documents and Records, the VPs shall conduct final review and shall be approved by the University President.
- Internal Audit, the VPs shall conduct final review and shall be approved by the University President.
- Control of Non-Conformity and Corrective Action, the VPs shall conduct final review and shall be approved by the University President.
- For work instructions of non-teaching processes, it should be prepared by originating department heads signed by the respective director; reviewed by the Vice-President who exercises supervision and control over the process; approved by the University President.
- For ACAD work instructions, a committee of deans and associate deans shall prepare the document, signed by the CIDQA director. It should then be reviewed by the VPAA and then approved by the University President.
- For system forms, it should be reviewed by the concerned VP, and approved by the University President. Academic forms shall be prepared by a committee comprised of deans, associate deans and CIDQA. Approval of new forms shall be reflected on the "Review and Approval Form" (Form. No. LSPU-DCO-SF-004).

Signatories

| Documented information | Prepared by | Reviewed by | Approved by |
|----------------------------------|--------------------|--------------|----------------------|
| Quality Manual | None | All VP's | University President |
| PM01 | DCO | All VP's | University President |
| PM02 | Lead Auditor | All VP's | University President |
| PM03 | CIDQA/Lead Auditor | All VP's | University President |
| Work Instructions (non-teaching) | Director | VP in charge | University President |
| Work Instructions (Academics) | CIDQA Director | VPAA | University President |
| System Forms (non-teaching) | Director | VP in charge | University President |
| System Forms (Academics) | Academic Committee | VPAA | University President |

- 4.2.3 Approved new document (including form) shall be endorsed to the Documents Controller and stamped "MASTER COPY" on each page (except for Reference/Equipment manuals/books which shall be stamped on the first page only) and stamped "RECEIVED" (first page only) with the affixed date of receipt.
- 4.2.4 The originating department shall determine the necessary distribution indicated in the distribution list, a copy that shall be given to the DCO. The document shall be reviewed against the Document Masterlist by the DCO to check any affected document/s. New documents which are not yet in the masterlist shall be temporarily noted and be reflected in the next issue.
- 4.2.5 Updating of the Document Masterlist shall be done every six (6) months. All documents' current revision status shall be identified in the masterlist and shall be used as a guide to prevent unintended use of obsolete document.
- 4.2.6 Issued documents (internal and external) shall be stamped "CONTROLLED" on each page and "ISSUED" (first page only) with affixed date of receipt/signature of Document Control Officer/Coordinator except for reference equipment manuals/books which shall be stamped "CONTROLLED" on the first page only.
- 4.2.7 Once 'CONTROLLED' copies are issued to the originating department by the DCO, the originating department shall reproduce and distribute the documents as indicated in their distribution list. For SYSTEM FORMS distributed, copies that are NOT stamped "CONTROLLED" are to be made available for use.



Sample Template of Distribution List

| Distribution List | | |
|------------------------------------|------------------|---|
| Document Title | Document Number | Offices to be issued copies |
| Quality Manual | LSPU-QM | OUP MR VPAA, VPA, VPRDE OCD Process Owners - thru website |
| An Outcomes Based Learning Program | LSPU-ACAD-SF-015 | CAS, CTE, CCS, CBMA, CHMT, CCJE, COE, CONAH, CA, CoF, CFND, CIT |
| CMO xxx | external | CTE, Registrar, CIDQA, VPAA |

- 4.2.8 Document Control Office can set specific date of deadline for the submission of documents to be controlled. Units/ Offices who will not meet the set date of deadline can still submit new/ revised documents but this will be for trial use only. These documents for trial will be controlled in the next updating of masterlist.

4.3 Document Review, Revision and Re-approval

- 4.3.1 Controlled documents shall be reviewed regularly (within 12 months from previous review) for adequacy and suitability. Results of review shall be carried over on the review report.
- 4.3.2 In case of any change/s in the content of the controlled document or form, the originating department should request for "Document Change Notice" (Form no.: LSPU-DCO-SF-001) for review and re-approval by the same persons who performed original review and approval, unless otherwise specifically designated in the Document Change Notice form.
- 4.3.3 All controlled (revised) documents shall be affixed with a "Document Revision Record" (Form no.: LSPU-DCO-SF-002) for its revision description history.

4.4 Filing, Availability, Retrieval and Storage

- 4.4.1 Every department is responsible in filing and properly storing their documents and Records.
- 4.4.2 All documents/records shall be available anytime at point of use and shall be filed accordingly in binders/ folders with proper labels for easy retrieval and to prevent damage, deterioration and loss.
- 4.4.3 Documents Controller should randomly check documents every six (6) months to ensure its availability at point of use. Results of checking shall be registered in a logbook.

4.5 Legibility

- 4.5.1 All documents and records shall be ensured of its legibility.
- 4.5.2 Controlled documents and records of any form should not use thermal paper or fax.
- 4.5.3 The use of correction fluid or pencil is not permitted.
- 4.5.4 To correct documents, draw a straight line across the entire word/s, number or alphanumeric series and write your name and signature as well as the date you made the correction.

4.6 External Documents

- 4.6.1 External Documents are documents coming from external sources such as international standards, statutory and regulatory requirements, specifications, drawings, equipment manuals, and reference books.



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- 4.6.2 All received external documents including soft copies shall be reviewed by the receiving unit/department/office using the Review and Approval Form (Form no.: LSPU-DCO-SF-004) prior to submission to Documents Control Center except for statutory and regulatory requirements since these are already reviewed by governing agencies prior to implementation.
- 4.6.3 All external documents received by the Documents Controller shall be stamped "CONTROLLED" on each page and "RECEIVED" (first page only) with affixed date of receipt/signature of the recipient except for reference equipment manuals/books which shall be stamped "CONTROLLED" on the first page only.
- 4.6.4 Document Controller shall register the external document received in the Document Masterlist (Form no.: LSPU-DCO-SF-003).
- 4.6.5 Soft copy documents will not be stamped controlled but will be only registered in the Document Master list.
- 4.6.6 The receiving unit/department shall identify the distribution of the received document and shall be reflected on the distribution list of the unit/department.
- 4.6.7 The Document Controller is NOT required to maintain a copy of any external document in book or manual form.

4.7 Obsoleting and Retrieval

- 4.7.1 Obsolete documents are the responsibility of the receiving department/unit. Obsolete 'CONTROLLED' documents must be retrieved or recalled upon issuance of the newly revised or updated documents.
- 4.7.2 Master copies of the Document Controller shall be stamped "OBSOLETE".
- 4.7.3 Obsolete original documents must be stored for reference purpose and will be disposed as per 4.9.
- 4.7.4 Records for archive shall be endorsed to Document Controller or Records Committee by the department owner for processing as per National Archives of the Philippines.
- 4.7.5 Documents and records must be properly labelled such as name of records, date covered (month and year) and are placed in the cabinets to ensure easy retrieval and to protect it from damage, deterioration and loss.
A log sheet is provided for the control of all documents and records being archived.

4.8 Security ,Integrity and Confidentiality

- 4.8.1 LSPU adopts the policies on protection of privacy anchored in Data Privacy Act of 2012.
- 4.8.2 Only officials authorized by the University President shall have access to the files to ensure protection and confidentiality of records.
- 4.8.3 Confidential information shall not be released to any unauthorized individual except with the written consent of the employee and approval of the University President/ Campus Director.
- 4.8.4 Use appropriate paper size when printing/ photocopying to ensure completeness and integrity of document/s.

4.9 Retention

Please refer to Records Disposition Schedule.

4.10 Disposition

- 4.10.1 All records/documents intended for disposition as per 4.9 shall be recycled, shred or sold.



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5.0 Records

Records are filed and maintained as per 4.5 to 4.8.

6.0 Responsibility

It is the responsibility of the document controller that the above procedure is properly implemented.

7.0 References

Records Disposition Schedule

RA 10173/ Data Privacy Act 2012

LSPU-DCO-SF-001: Document Change Notice

LSPU-DCO-SF-002: Document Revision Record

LSPU-DCO-SF-003: Document Masterlist

LSPU-DCO-SF-004: Review and Approval Form

LSPU-DCO-SF-005: Distribution and Retrieval Form

Prepared by:

AREA A. REDONA

Document Control Officer

Date: Sept. 23, 2019

Reviewed by:

CORAZON N. SAN AGUSTIN, Ph.D.

Vice President for Research Development & Extension

Date: Sept. 25, 2019

EDEN C. CALLO, Ed.D.

Vice President for Academic Affairs

Date: Sept. 25, 2019

ENGR. BELTRAN R. PEDRIGAL

Vice President for Administration

Date: Sept. 25, 2019

Approved by:

MARIO A. BRIONES, Ed.D.

University President

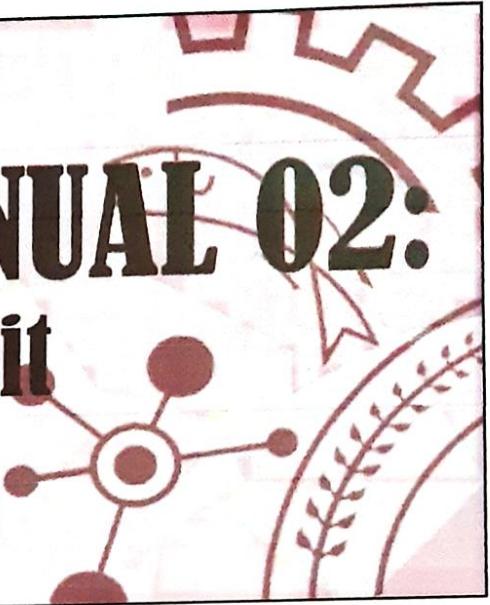
Date: October 2, 2019

PROCEDURE MANUAL 02:

Internal Audit



Republic of the Philippines
Laguna State Polytechnic University
Province of Laguna





1.0 Scope

The procedure covers the internal quality audit process from audit planning and scheduling to follow-up audits and reporting.

2.0 Objective

To document, establish, implement and maintain an internal audit procedure for an effective implementation of the established quality management system.

3.0 Reference Documents

ISO 9001:2015 : International Standard Quality Management System Requirements

ISO 19011:2011 : Guidelines for Auditing Management Systems

LSPU-QM : Quality Manual

LSPU-PM-01 : Control of Documents and Records

LSPU-PM-03 : Control of Non-Conformity and Corrective Action

4.0 Procedure

4.1 Planning and Scheduling

- 4.1.1 All quality system process elements shall be audited at least once a year as per Audit Master Schedule (LSPU-IQA-SF-001) which shall be approved by the University President. The schedule shall be formulated on the basis of the status and importance of the activity. However, a particular area of the entire quality system may be audited more frequently, when deemed necessary. Each campus will organize their scheduled internal audits accordingly, led by the team leaders.
- 4.1.2 The Lead Auditor shall furnish the team leaders and auditors with the objectives and scope of audit, the names of the team members, the department to be audited and other pertinent details before the scheduled audit date. This is to ensure the effectiveness of the audit.
- 4.1.3 The Lead Auditor and team leaders shall ensure that all copies of the necessary documents such as quality manual, procedures, previous audit results and all other relevant documents are available during audit.
- 4.1.4 The Audit Plan (LSPU-IQA-SF-002) should include the audit date, audit scope, audit objectives, criteria, audit team/auditors, time of audit, elements and areas to be audited and auditees.
- 4.1.5 The audit team shall prepare the necessary audit checklists to ensure that all the important items/ elements are covered.
- 4.1.6 The scope of the audit shall be referenced on the ISO standards, the quality manual, quality procedures and necessary work instructions, where applicable.
- 4.1.7 The section clauses or elements in the audit checklist shall be based on the audit plan.
- 4.1.8 The Lead Auditor and team leaders shall discuss the necessary preparations; formulations of the audit plan and other audit activities; timetable and preparation; and review of the audit scope and criteria.



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PROCEDURE MANUAL 02: Internal Audit

4.2 Selection of Auditors/Audit Team

- 4.2.1 Selection of lead auditor, team leaders and auditors will be based on the competence of the auditors from the "List of Qualified Auditors". Independence in conducting of audits shall be ensured by the University President and the Lead Auditor for objectivity and impartiality to avoid conflict of interest and bias in opinion during audit.
- 4.2.2 The University President and Campus Directors shall maintain the integrity of the audit by ensuring that neither the Lead Auditor nor any member of the audit team is/are member/s of the department or function to be audited. They shall have no direct responsibility on the activity being audited.
- 4.2.3 The audit team shall be composed of qualified and trained internal quality auditors. The minimum qualification for the internal quality auditors are that they must at least be a bachelor degree holder, with total work experience of at least one (1) year and have attended an IQA training/seminar of at least 24 hrs.
- 4.2.4 The audit team consisting of the qualified auditors shall be nominated by the Lead Auditor and team leaders prior to the audit.

4.3 Opening Meeting

- 4.3.1 An opening meeting shall be conducted by the lead auditor (or team leaders in respective campuses) prior to proceeding with the audit; to be participated by the audit team, auditees and involved departments if necessary. The objective of the meeting is for familiarization and awareness of the participants on the mechanics of the entire audit process.

4.4 Conduct of Audit

- 4.4.1 Using the applicable documents and the Audit Plan, the lead auditor, team leaders and the team members shall conduct the audit by interviewing the auditee at the area being audited or desk audit (review of the applicable documents), and/or checking of actual implementation against documented procedures.
- 4.4.2 The auditor shall note down findings during the time of audit, such as objective evidence of conformities and/or non-conformities.
- 4.4.3 The University President should evaluate the competence of the Lead Auditor while the Lead Auditor/Team Leaders will evaluate the competence of the Internal Quality Auditors. Refer to Auditors Performance Evaluation form (LSPU-IQA-SF-006).
- 4.4.4 All findings that may result in a breakdown of the QMS, a failure in the services of the University, or a failure to meet a requirement shall be classified as Non-conformity (NC). Findings would be labeled an Opportunity for Improvement (OFI) if it can lead to potential non-conformity but can still be improved.
- 4.4.5 a) Non-Conformity (NC)
 - Absence of procedure required by the standard.
 - Non-implementation of a procedure required by the standard.
 - A lapse in the implementation of the management system.
 - An isolated lapse in an implemented management system requirement.
 - Health and safety requirement not implemented.b) Opportunity for Improvement (OFI)
 - All areas of concern that would lead to non-conformities.



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- Suggestions or recommendations of best practices.
- Improvement possibilities of the system.

4.4.6 The lead auditor shall discuss with the auditee the results of the audit.

4.4.7 The audit team shall evaluate their findings and deliberate on the non-conformity found during the audit. Final decision as agreed upon by the audit team must be reflected on the audit report. Unresolved issue by the team shall be decided by the Lead Auditor or the Campus Director.

4.5 Closing Meeting

4.5.1 Closing meeting shall be conducted as soon as the audit has been finished. Similar participants during the opening meeting are expected to attend the closing meeting.

4.5.2 The Lead Auditor/Team Leader will discuss the results of the audit. Summary of findings called-out during the audit shall be presented. Unresolved issues with the auditee are elevated to the Campus Director or University President. They will likewise agree to the follow-up action to be taken as scheduled.

4.6 Reporting

4.6.1 The final basis for the results of the audit shall be formalized through internal audit report which will be prepared by the Lead Auditor/Team Leaders for review and approval of the respective Campus Director.

4.6.2 All auditees with findings shall be issued with a Non-conformity/Corrective Action Report (NCAR) but distribution of audit report will be as per discretion of the Campus Director.

4.6.3 Correction as necessary, corrective action shall be initiated and implemented by the auditee/Department Head to be documented through the NCAR and coordinated with the Lead Auditor/Team Leader. For details on the investigation, refer to control of non-conformity and corrective action procedures. (PM03)

4.6.4 All results of the internal quality audit shall be an input to the management review meeting for continuous improvement.

4.6.5 Corrective actions not implemented on the committed date shall be elevated to the CD for further disposition.

4.6.6 Corrective actions are then declared "closed" once verified to be effective upon approval of the CD/University President.

4.7 Follow-up Audit

4.7.1 A follow-up audit shall be conducted minimum of two (2) days after implementation of the corrective action even without prior announcements to verify if the committed action is implemented and preferably minimum of one (1) month after another follow-up audit will be done to verify the effectiveness of the implemented action. This must be recorded in the Corrective Action Monitoring Log.

4.7.2 To maintain the continuity of the audit, preferably, the same audit team may be assigned to do the follow-up audit if necessary.



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PROCEDURE MANUAL 02: Internal Audit

5.0 Records

5.1

List of Qualified Auditors

| | |
|-----------------|---|
| LSPU-IQA-SF-001 | : Audit Master Schedule |
| LSPU-IQA-SF-002 | : Audit Plan |
| LSPU-IQA-SF-003 | : Audit Checklist |
| LSPU-IQA-SF-004 | : Audit Report |
| LSPU-IQA-SF-005 | : Auditor Evaluation Checklist |
| LSPU-IQA-SF-006 | : Auditors Performance Evaluation form |
| LSPU-IQA-SF-008 | : Corrective Action Monitoring Log |
| LSPU-IQA-SF-007 | : Non-conformity/Corrective Action Report |

- 5.2 Internal quality audit records will be maintained and filed by the lead auditor in accordance to control of documents and records procedure.

6.0 Responsibility

It is the responsibility of the University President thru the Campus Directors, and the Lead Auditor to ensure that the above procedure is implemented.

Prepared by:

HOSEAL B. GAYMAN, R.L.

Lead Auditor

Date: Sept. 23, 2019

Reviewed by:

CORAZON N. SAN AGUSTIN, Ph.D.

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Date: Sept. 25, 2019

EDEN C. CALLO, Ed.D.

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Date: Sept. 25, 2019

Engr. BELTRAN P. PEDRIGAL

VPA

Date: Sept. 25, 2019

Approved by:

MARIO B. BRIONES, Ed.D.

University President

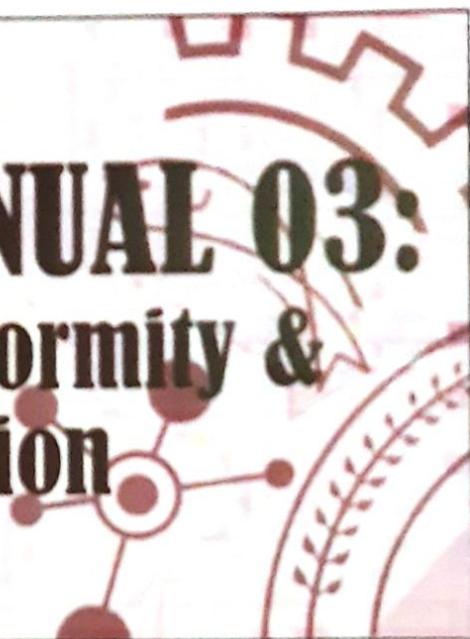
Date: October 2, 2019

PROCEDURE MANUAL 03:

Control of Non-Conformity & Corrective Action



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PROCEDURE MANUAL 03: Control of Non-Conformity and Corrective Action

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Date: July 16, 2018

1.0 Scope

This procedure is applicable to all products/materials, process and system non-conformities including customer feedbacks/complaints and unmet quality objectives' targets. Risk treatment may also be documented using this procedure.

2.0 Objective

To establish and maintain documented Control of Non conformity and Corrective Action procedures to ensure effective implementation of the actions.

3.0 Reference Documents

- | | |
|---------------|--|
| ISO 9001:2015 | - Quality Management System Requirements |
| LSPU-QM | - Quality Manual |
| LSPU-PM-01 | - Control of Documents and Records |
| LSPU-PM-02 | - Internal Audit |

4.0 Procedure

- 4.1 All non-conformities detected as a result of defective product/material, unmet goals/ objectives and targets, customer complaints, unsatisfactory results of customer survey, audit findings and service related non-conformities, must be recorded and identified. Investigation of the cause must define the nature and extent of the non-conformity.
- 4.2 Any affected personnel upon observance of a non-conformity as stated in item 4.1 can raise a Non-Conformity Report or inform the head of the involved department about the non-conformity observed.
- 4.3 The involved department shall record the non-conformity into the Non-Conformity and Corrective Action Report or NCAR (LSPU-IQA-SF-007).
- 4.4 For product or material he/she shall identify and segregate the non-conforming product/material and dispose as follows:
 - a) Condemned or
 - b) Reject and return to supplier
- 4.5 Disposition must be reviewed, agreed and implementation must be verified through inspection and/or test as applicable. Records of accepted non-conforming product or material must be recorded.
- 4.6 Correction and Corrective Action
 - 4.6.1 The department concerned shall be responsible for the timely investigation on the probable root cause of the problem (not needed for OFI's).
 - 4.6.2 Immediate action/Correction shall be taken to eliminate a detected non-conformity except for Opportunities for Improvement (OFI). This can be made in conjunction with corrective action.
 - 4.6.3 Corrective action shall be taken to eliminate the cause of a detected non-conformity to prevent the non-conformity recurrence. OFI's are to be corrected for continual improvement. These can be initiated by any staff responsible for the non-conformity/s or OFI as a result described in item 4.1.



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- 4.6.4 The Dean/Director will follow-up on implementation of action. Chairpersons will invite their Dean/Director to visit or verify evidence of implementation of corrective action needed to eliminate the problem's recurrence. For NC's and OFI's raised in the internal audit, auditors shall verify implementation.
- 4.6.5 Verification of effectiveness shall be done by the Management Representative, University President or Campus Director in their respective campuses. Application of controls to ensure the effectiveness of the action taken shall be determined. These shall be recorded in the NCAR.

4.7 Risk

The monitoring of risk treatment, measures and corrective action may be done through the following but not limited to meetings, workshops and analysis of process owners.

- 4.7.1 A consolidated Risk Register will be maintained by the Management Representatives. Deans and Directors must have a copy of their respective register entries.
- 4.7.2 Process owners may document the management of their risk through the NCAR or opt to use their own monitoring methods.
- 4.7.3 Relevant Information and risk treatment actions taken shall be discussed during the regular Management Review meetings. The treated risks shall be recorded in the Risk Register.

4.8 Customer Complaints

- 4.8.1 Any validated report or feedback from students and parents/guardians which is treated as complaint shall be handled by the Office of Student Affairs and Services, and shall be recorded through the NCAR. Refer to complaints procedures of the Office of Student Affairs and Services.
- 4.8.2 Other formal complaints aside from students and their parents/guardians shall be forwarded to the campus director

4.9 Verification

- 4.9.1 Corrective actions implemented shall be logged by the assigned personnel in the corrective action monitoring log form and will be monitored and regularly updated to verify its effectiveness.
- 4.9.2 The Management Representative, Campus Director and/or the OSAS head (for customer complaints) shall approve the verification. See 4.6.5.
- 4.9.3 All necessary changes brought about by the implementation shall be reflected in the affected documented procedure or relevant work instructions as applicable.



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5.0 Records

Records are filed and maintained as per control of documents and records procedure-LSPU-PM-01.

6.0 Appendices

LSPU-IQA-SF-007 : Non-conformity and Corrective Action Report

LSPU-IQA-SF-008 : Corrective Action Monitoring Log

Prepared by:

HOSEAL B. GAYMAN

Lead Auditor

Date: July 10, 2018

Reviewed by:

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VPRDE

Date: July 14, 2018

EDEN C. CALLO, Ed.D.

VPAAC

Date: July 14, 2018

Approved by:

EFREN R. DELA PAZ, J.D.

Management Representative

Date:

July 16, 2018