Corrective Action Plan for Pharmaceutical Service Quality Audit

Date: [Insert Date]

Audit Reference Number: [Insert Reference Number]

Department: [Insert Department]

Prepared by: [Insert Name]

Findings

Finding Number	Description	Impact	Root Cause
1	[Description of Finding]	[Impact of Finding]	[Root Cause]

Corrective Actions

Action Number	Corrective Action	Responsible Person	Target Completion Date	Status
1	[Description of Corrective Action]	[Responsible Person]	[Target Date]	[Status]

Follow-Up

The effectiveness of the corrective actions will be reviewed on [Insert Review Date].

Approval

Prepared by: _____

Approved by: _____