Romblon State University
Procedures Manual

"RSU, Pushing Aggressively to Make a Difference"

Republic of the Philippines
ROMBLON STATE UNIVERSITY
Odiongan, Romblon

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PROCEDURES MANUAL

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1.0 Objectives

The purpose of this document is to define the procedures on the admission and registration of new students and transferees who wants to enter in the university. The procedure includes entrance examination test, medical/dental examination, guidance interview, submission of admission requirements, encoding of personal information, printing and approval of enrolment form and payment.

2.0 Scope

This process is applicable to all students who wish to enter in the university whether new or old students, transferees, graduate students, and professionals taking up complete education program.

3.0 Definitions

Admission refers to the prescribed entrance requirements which shall determine the fitness of the student to enter the University.

Irregular student is a student who is registered for normal credits but who does not carry the subjects for a full load called for in a given semester by the curriculum.

Registration is the process of entering information in a book or system of student who has met the prescribed requirements for entry to the University.

Regular student is a student who is registered for normal academic credits and carries the courses required for in a given semester by the curriculum.

Returnees are former students who have been out of the school for at least three semesters.

Shifters refer to students who intend to shift from one major course to another.

Unit-earners are students who intend to earn units in a particular College/Department.

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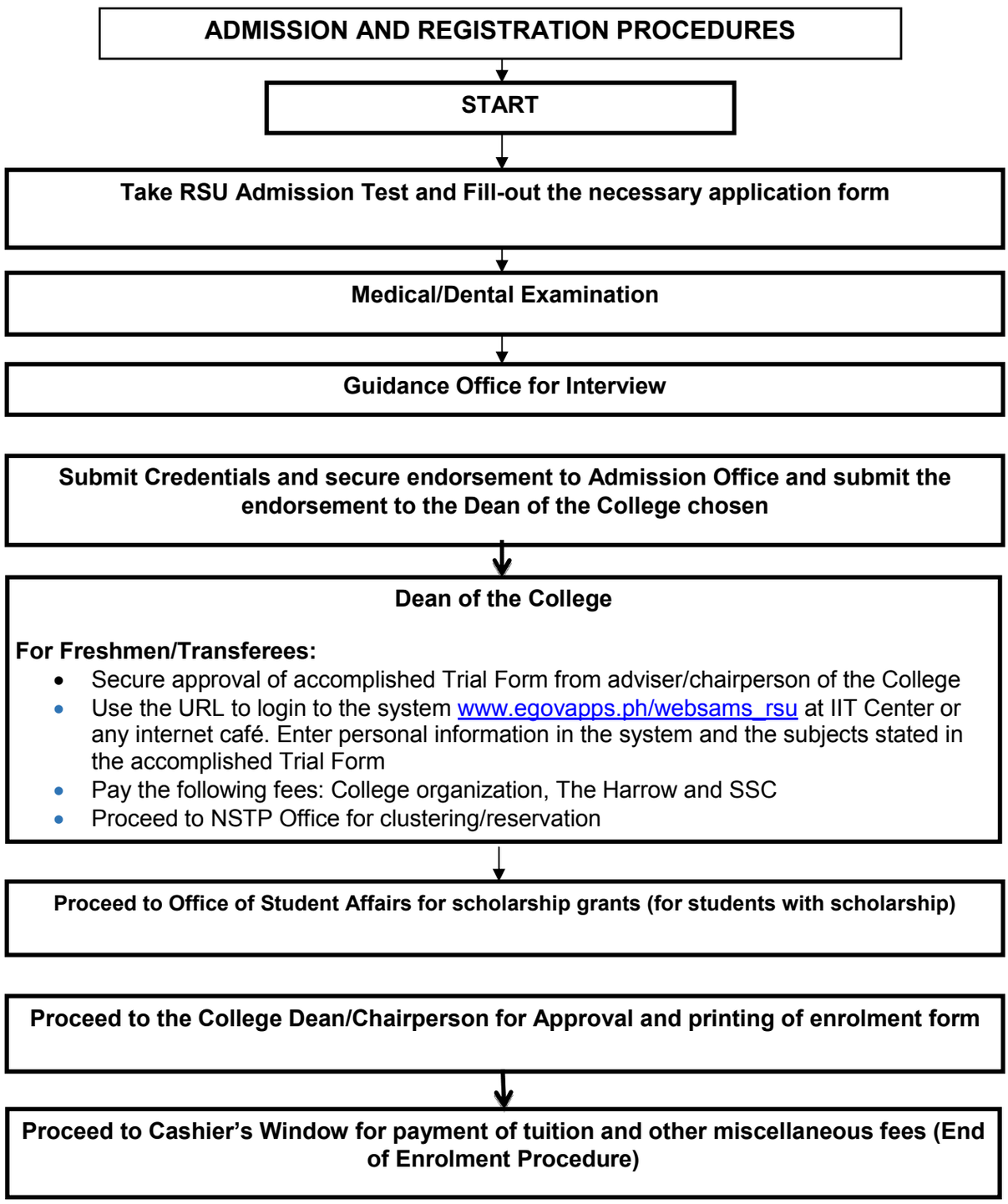
4.0 Procedure



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5.0 Procedure Details

Step No.	Details
1	The new students/transferees who wish to enter in the University should take College Admission Test and fill-out the necessary application form for admission.
2	The new students/transferees will ask the result of RSU-CAT from Office of Admission and proceed to Medical/Dental Clinic for examination.
3	The new students/transferees will proceed to Guidance Office for interview
4	The new students/transferees who were accepted in the University should submit admission requirements such as photocopy of birth certificate, 2 pcs. 2x2 ID picture, original copy of High School Report Card/Transcript of Records, and Certificate of Good Moral Character/Honorable Dismissal to the Office of Admission and seek endorsement form and submit it to the Dean of the College chosen.
5	The new students/transferees should secure approval of accomplished Trial Form from adviser/chairperson of the College chosen; use the URL to login to the system www.egovapps.ph/websams_rsu at IIT Center or any internet café. Enter personal information in the system and the subjects stated in the accomplished Trial Form; pay the following fees: College organization, The Harrow and SSC; and proceed to NSTP Office for clustering/reservation
6	For new students with scholarship, they may proceed to the Office of Student Affairs for scholarship grants
7	The new students/transferees may proceed to the College Dean/Chairperson for approval and printing of enrolment form.
8	After printing of enrolment form the new students/transferees may proceed to Cashier's window and pay the necessary tuition and other miscellaneous fees.

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6.0 References

Document Title	Document Code
University Code	
Student Handbook	
Admission and Registration Manual	

7.0 Records

Record	Custodian
RSU-CAT Admission Test Booklet	
RSU-CAT Answer Sheet	
Application Form for College Admission	
RSU-CAT Examination Result Form	
Endorsement Form	

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1.0 Objectives

The purpose of this procedure is to define the University processes for undertaking internal audit in order to assess the effectiveness and adequacy of the Quality Management System (QMS) in meeting ISO 9000:2008 International Standards; ensure that the QMS continues to operate in line with specified policies, procedures and external requirements; the QMS is effectively implemented and maintained and necessary improvements to the QMS are identified and initiated.

2.0 Scope

The scope of this procedure applies to all units of the organizations defined in the Quality Management System. The focus is to assess the effectiveness of the organization's QMS. Covered by this procedure are the work units within the Quality Management System whose processes directly or indirectly affect the quality of services provided to customers. This includes Academic, Academic Support and Management Support Units. By applying the principles of auditing, outlined by ISO 19011:2002, the University ensures that all internal audits are conducted with due diligence, integrity and independence. All conclusions derived from the audit are based upon objective and traceable evidence.

3.0 Definitions

Internal Quality Audit. This refers to the Internal Quality Audit performed to check the effectiveness of the implementation of the quality system.

Non-conformity. This refers to non-fulfillment of a specific requirements.

Preventive action. This refers to action taken to eliminate a potential non-conformity.

Corrective action. This refers to action taken to eliminate the cause of a non-conformity.

Audit. Refers to the systematic, independent documented process for obtaining and evaluating audit evidence objectively to determine the extent to which audit criteria are fulfilled.

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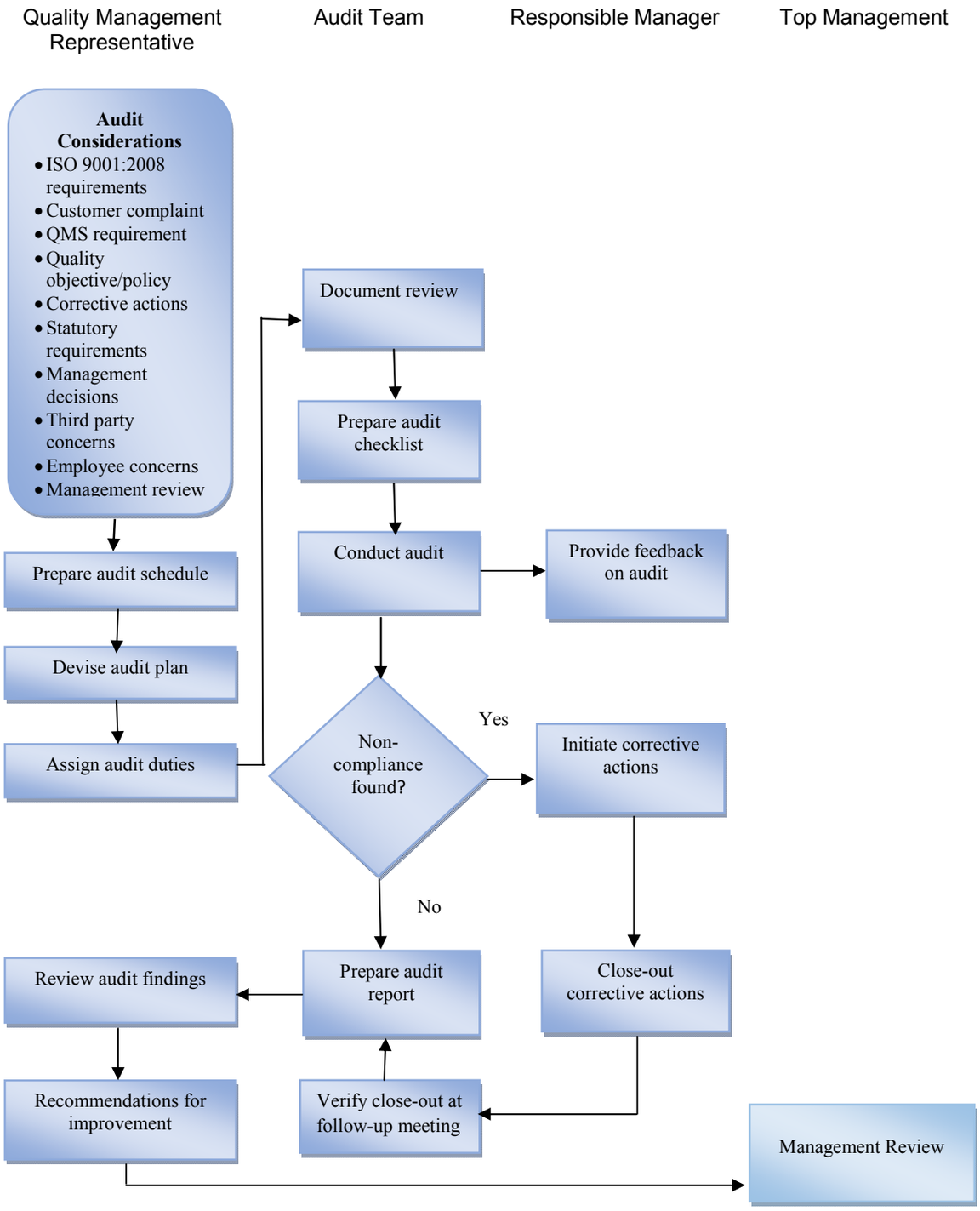
4.0 Procedure



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5.0 Procedure Details

Step No.	Details
1	The QMR initiate audit considerations on ISO 9001:2008 requirements, customer complaint, QMS requirements, quality objectives/policy, corrective actions, statutory requirements, management decisions, third party concerns, employee concerns and management review.
2	The QMR prepare audit schedule
3	The QMR devise the audit plan
4	The QMR assign audit duties to the Audit Team
5	The Audit Team review the documents received from the Management Quality Representative.
6	The Audit Team prepare the audit checklist
7	Conduct audit
8	The Responsible Manager provide feedback on audit conducted by the Audit Team
9	If the Audit Team found non-compliance, the responsible manager initiate corrective actions, close-out corrective actions, verify close-out at follow-up meeting and prepare audit report.
10	If the Audit Team found no non-compliance, the Audit Team prepare the audit report and submit to the Management Quality Representative for review of the audit findings and make recommendations of audit findings for improvement.
11	The Management Quality Representative forwarded the recommended audit findings to the Top Management.
12	Top management review the recommendations of audit findings improvement for approval and implementation.

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6.0 References

Document Title	**Document Code**
Quality Manual	
Guidelines on the Conduct of Internal Quality Audit Plan	
Preparation of Annual Internal Quality Audit Plan	

7.0 Record

Record	**Custodian**
Annual Internal Quality Audit Plan	
Notification Memo	
Corrective and Preventive Action Request	
Internal Quality Audit Report	
Minutes of Meeting	
Auditor's Notes	
Internal Audit Schedule	
Internal audit Assignment	
Internal Audit Feedback	

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1.0 Objectives

The purpose of this procedure is to ensure that any non-conformance in the system is addressed as soon as possible and that corrective and preventive action are taken, maintain and documented to ensure effective implementation of the actions in line with the University's quality management system.

2.0 Scope

This procedure is applicable to all products/materials, process and system non-conformances including customer feedbacks/complaints and unmet quality objectives. The procedure ensures that corrective and preventive action is undertaken appropriately to all areas of University's operational activities in case of non-conformity.

3.0 Definitions

Observation. Evidence of non-conformance which is deemed not to be a systemic failure of the management system as evidenced by the general level of conformance but which needs to be addressed.

Non-conformance. A significant deviation from work standards, practices, procedures, regulations, management system performance etc., either in number of occurrences or in seriousness. These are individual observations that are not addressed within a given timescale.

Major Non-conformance. A situation that requires immediate corrective action due to a situation which poses imminent danger; a significant breach in legislation; previously identified significant non-conformance(s) that has not been addressed or has been inadequately addressed.

Corrective and Preventive Action. Action taken to eliminate the cause of an identified non-conformance or other undesired situation.

Initiator. The person who identifies the incidence of non-conformance and initiates a Corrective and Preventive Action Report form.

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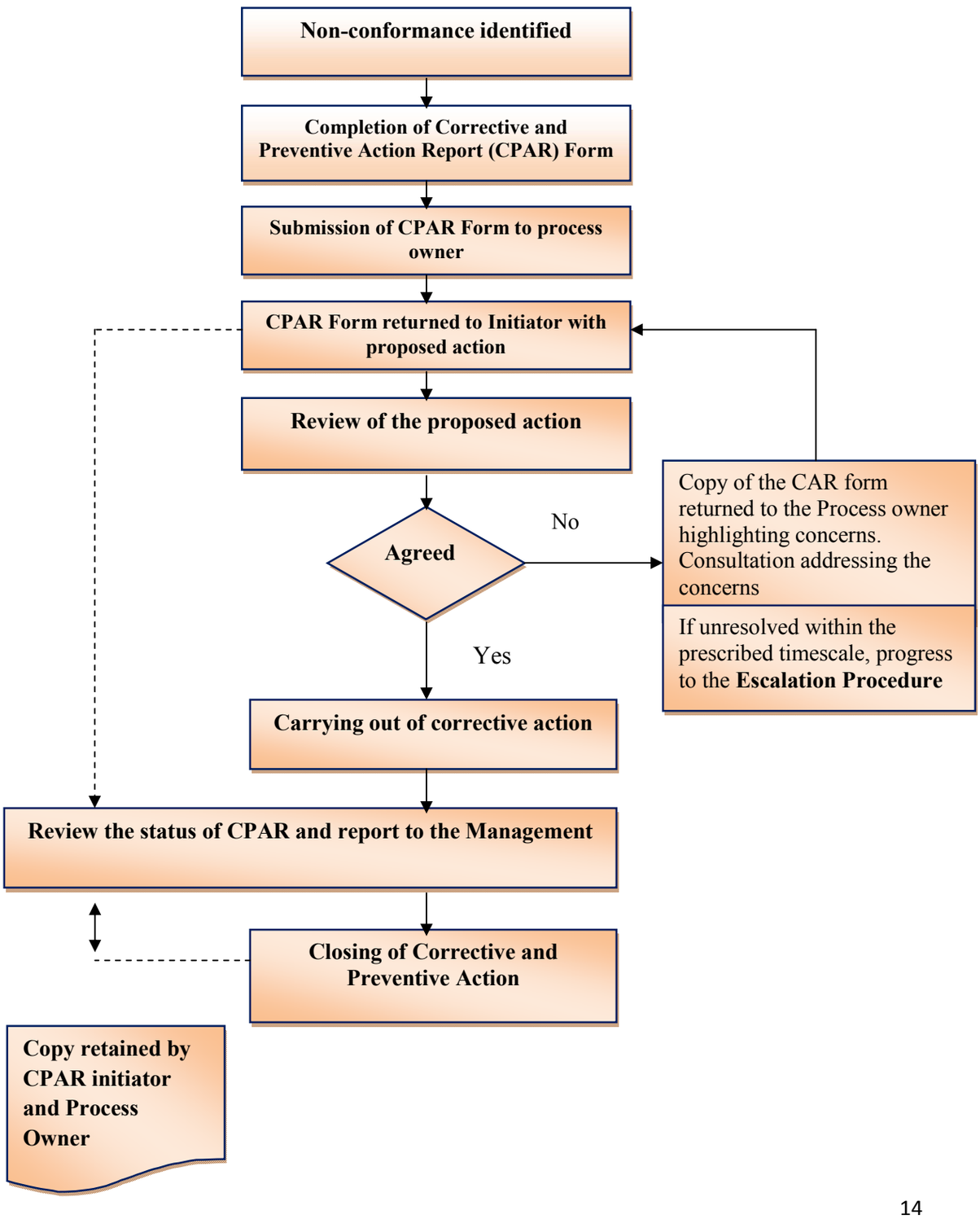
4.0 Procedure



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5.0 Procedure Details

Step No.	Details
1	Initiator of Corrective and Preventive Action Report form records details and completes CPAR Form.
2	The initiator Submits to the Process Owner.
3	Corrective and Preventive Action Report Form will be returned to Initiator with proposed corrective/preventive action.
4	Person initiating the Corrective and Preventive Action Report is responsible for evaluating the proposed actions and a copy is returned to the Process Owner. The CPAR remains OPEN until an effectiveness review has been undertaken.
5	Agreed? NO The Initiator of the Corrective and Preventive Action Report returns the copy of the CPAR form to the Process Owner highlighting concerns. There shall be a consultation on addressing the concerns. If unresolved within the prescribed timescale; progress to the Escalation Procedure
6	YES The corrective action is carried out by the Process Owner and effectiveness is reviewed independently by the person initiating the Corrective and Preventive Action Report within the timescale agreed.
7	Review the status of the CPAR and report to the Management.
8	When the actions are completed and there is evidence that they are effective, the CPAR is CLOSED by the initiator and a copy sent to the Process Owner. Copy shall be retained by CPAR initiator and Process Owner

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6.0 References

Document Title	**Document Code**
ISO 9001:2008 – Quality Management System Requirements	
Quality Manual	
Control of Documents and Records	
Internal Audit	
Inspection Procedure	
University Code	
Corrective and Preventive Action Request Form	
Procedure Manual on Corrective and Preventive Action	

7.0 Records

Records are filed and maintained as per control of documents and records procedure as stipulated under Control of Documents and Records.

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1. 0 Objectives

This procedure defines the method for preparing, reviewing, approving, maintaining, tracking, changing, proper flow, handling and control of essential documents affecting the products/service quality of Romblon State University in accordance with the Quality Manual.

2.0 Scope

This procedure covers all documents that will be subject for initiation, review, approval, issuance, revision, control and maintenance such as quality manual, procedure manuals, admission and registration manual, work instructions, standard operating procedures (SOPs), technical specifications, syllabus, operations manual, applicable statutory and regulatory requirements, international standards and applicable records and documents pertaining to the Quality System designed for general dissemination to all operating and support units of the University.

3.0 Definitions

Records Management Officer (RMO). This refers to the person responsible for the control of all documents and data that relate to the requirements of ISO 9001:2008.

Document. This refers to any Quality System procedure, work instruction, manual, or associated form that is used to control the processes that affect the quality of the final product/service.

Document Control Form (DCF). This refers to the form used to create or change a document.

Master List. This refers to the list that identifies the Quality System documents and data and includes current revision status.

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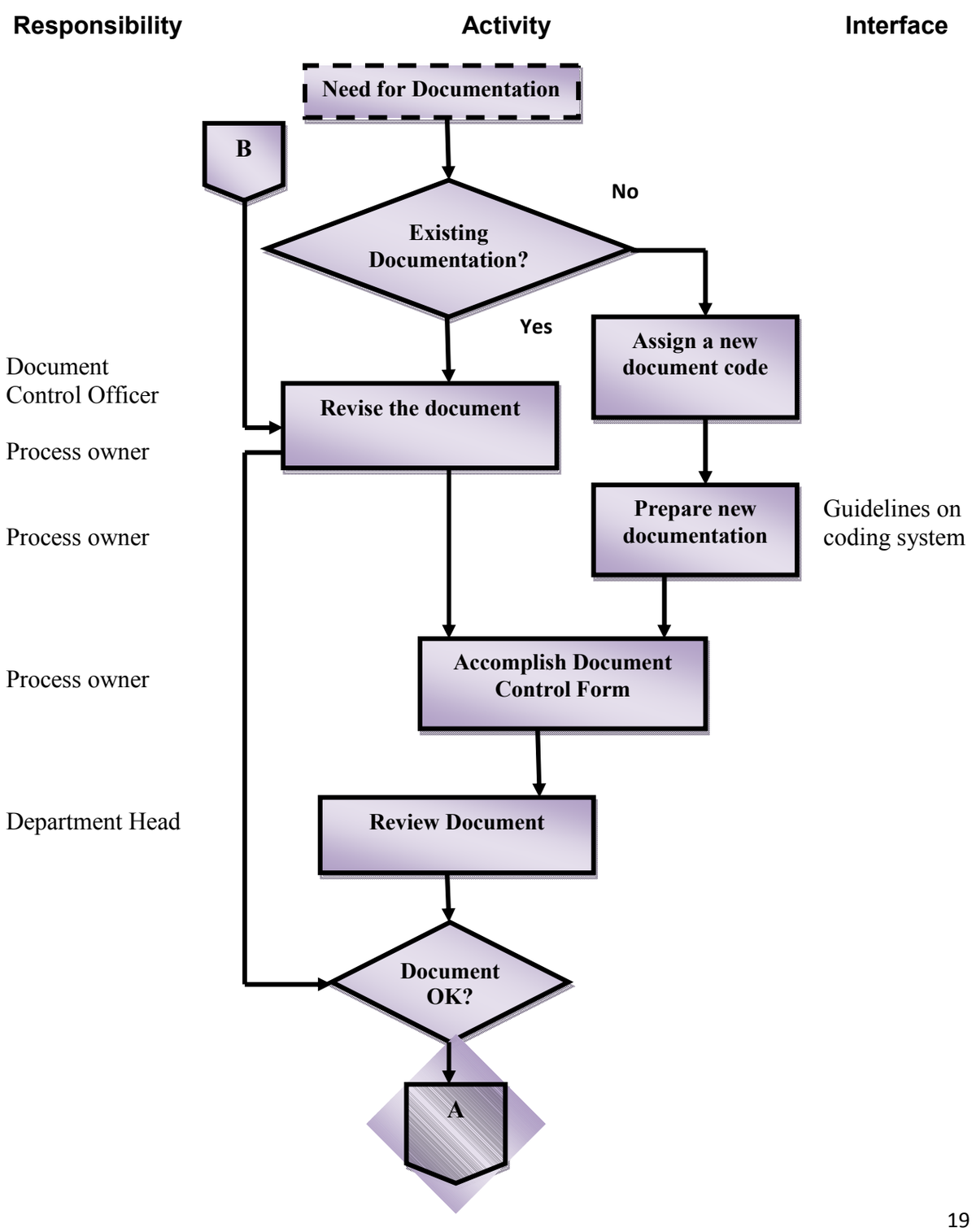
4.0 Procedure



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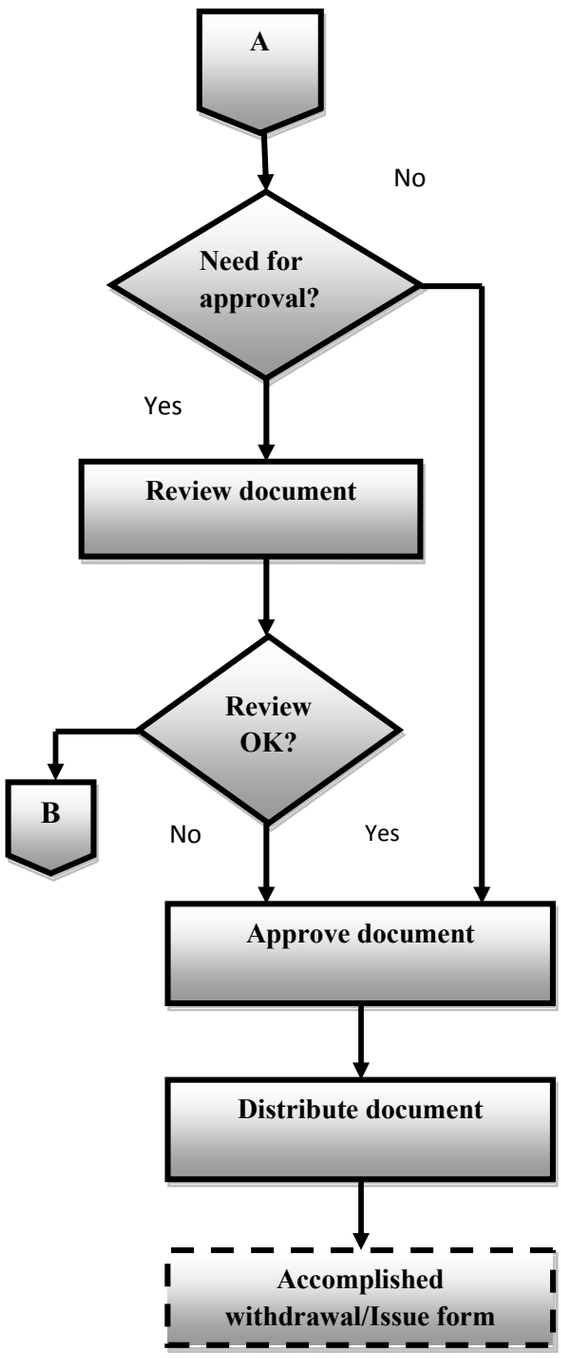
Responsibility	Activity	Interface
Department Head		
Department Head		
Document Control Center/Process owner		Guidelines on control and distribution of document

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5.0 Procedure Details

Step No.	Details
1	The concerned process owner shall check the masterlist to verify that the creation or revision of the document has not already been done.
2	To prepare new documents, a Document Code shall be assigned following Guidelines on Coding System.
3	For new documents, the process owner shall draft a document using standard templates to determine what template to use and how to properly accomplish them.
4	To revise documents, the Document control Officer/Process Owner shall underline the sentences that have been revised or included in the document. Indicate corresponding changes in the revision history at the first page of every document. For revisions on documents that were already revised (those underlined revisions), use soft copy with the latest revision and remove all underlines on previous revisions before encoding the latest revisions.
5	Accomplished Document Control Form.
6	The Department Head concerned shall review the proposed document. If amendments are necessary he shall return the document to the originator for modifications.
7	Department Head shall identify if approval is needed for the documentation. If so, he/she shall forward the document to Top Management for review.
8	Top Management shall review the proposed document. If necessary amendments are required, the document shall be returned to the originator for modifications.
9	If the document is a Quality Manual document, the top management shall approved and sign the document. If the document is a procedure or work instruction document, only the concerned Department Head shall approve the document.
10	The approve document is registered at the Records Management Office and it is provided with a control stamp. Necessary changes and distribution in the Masterlist of Controlled Documents shall be made following the Guidelines on Control and Distribution of Documents.

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6.0 References

Document Title	Document Number
Guidelines on Coding System	
Guidelines on control and Distribution of Documents	
ISO 9001:008 Quality Management system Requirements	
Quality Manual	
Internal quality Audit	
Control of Non-conformance, Corrective and Preventive Action	
RA 9470 NAP General Circular No.1, Jan. 20, 2009; National Archives of the Philippines Act of 2007	

7.0 Records

Records are filed and maintained as Section 6.2.3 and 6.2.4

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1.0 Objectives

The purpose of this manual is to establish the procedure on the control of records generated in the implementation quality system. This procedure shall ensure that records are identified, collected, indexed, accessed, filed, retained, maintained, disposed, and stored within the Quality Management System.

2.0 Scope

The scope of this procedure applies to all departments/units in the organization defined in the Quality Management System. Covered by this procedure are the designated quality records identified in the record quality system including the identification of record, checking the code, filing, checking and disposing of obsolete records.

3.0 Definitions

Record. This refers to a document stating results achieved or providing evidence of activities performed.

RMO. Records Management Office or the Records Management Officer responsible for interpreting and assisting in implementing records management system.

Quality Record. Record required in Table 1 of PM-DCC-002 (this document) or specifically identified as a quality record in a given process or procedure.

Process Owner. Person having the responsibility and authority to accomplish/implement a specific activity or process.

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4.0 Procedure

Responsibility	Activity	Interface
	Need to create new record	
Process owner	Identify type of record	Masterlist of record
Process owner	Create new record	Guidelines on coding system
	Existing File? (Yes / No)	
Process owner	Create new file	Masterlist of records
Process owner	Update Master list	Masterlist of records
Process owner	Update filing system	Masterlist of records Guidelines on Coding System
Process owner/DCC Officer	Submit master list	Masterlist of records
	New record created/Updated master list	

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5. Procedure Details

Step No.	Details
1	The process owner use Quality Records in the ISO 9001:2008 QMS Standard, with specific reference section in the ISO 9001 QMS. The QMS documents referenced in the table identify where equivalent versions of these Quality Records Masterlist
2	Using the designated form, the process owner creates new record to ensure that the form is the latest form. If there is a need to create a new form, the process owner shall follow guidelines on Coding System.
3	The concerned process owner identify those records that needs to be stored, retrievable, secured and well maintained in consultation with the Quality Management Department in accordance with the requirements of TESDA, CHED, and third party contracts (outsourced processes). The masterlist of records such as Record Code, Record Name, Location, Responsible Person, Disposition and Retention Period shall be maintained and updated. **Record Code**. Refers to record number (Please refer to Guidelines on Coding of Document GL-DCC-001) **Record.** Name Records shall be appropriately identified by a descriptive title clearly labeling the record. **Location.** Refers to location where active records are kept. All records shall be physically or electronically filed by a method, which enhances accessibility and retrieval by a user. If electronic files are used, a back-up system or other suitable measures to prevent record loss should be implemented. If your process includes a disaster/business recovery program, it should be specified under this section.

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	Custodian. Records shall be readily accessible to individuals requiring information contained in the record. Custodian refers to the person that may access the records or through whom the Records may be accessed.
3	**Disposition**. Defines how the Records are to be disposed when the retention period has been exceeded. Disposition may be to discard or destroy the records, or for Head office one has to contact the Records Management Office for instruction on long-term storage. The Records Committee shall review/evaluate all decisions on records disposition. **Retention Period.** refers to how long it is kept at the department before it is either discarded or destroyed, or sent to off-site for long-term storage. Quality records shall have their respective retention period.
4	The Record Management Officer filed the new record in its corresponding location and check and dispose accordingly obsolete records based on the retention period declared in the Masterlist.
5	The Process Owners shall submit the original copy of the Masterlist of Quality Records to the Records Management Officer (RMO) and the RMO shall issue a copy of Masterlist of Quality Records to the Process Owners.

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6. References

Document Title	**Document Code**
Guidelines on Document System	
Filing Management Record	

7. Records

Record	**Custodian**
Masterlist of quality Records	Process Owner

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APPENDICES

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Title: Control of Non-conformance, Corrective and Preventive Action

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Appendix A

NON-CONFORMANCE/CORRECTIVE/PREVENTIVE ACTION REPORT (NCPAR)

NCPAR No. _____ Date: _____

Department/Unit:
1. Details: Nonconformance raised as a result of: [ ] Material or Product [ ] Unmet Goals/ Objectives [ ] Customer Complaints [ ] Service Non conformance [ ] Internal Audit [ ] Customer Satisfaction Survey [ ] Potential Nonconformance [ ] Others
2. Description of [ ] Non-Conformance [ ] Potential Nonconformance [ ] Improvement Detected by: Date:
3. Disposition: (For Material /Product only - Optional) [ ] Rework/ Repair [ ] Use as is [ ] Reject & return to supplier [ ] N/A Proposed by: Date:
4. Investigation: [ ] Cause of non-conformance: [ ] Potential non-conformance Conducted by: Date:
5. Corrective/Preventive Action:
[ ] Correction (Immediate Action or Containment Action): Responsible: Date:
[ ] Corrective Action: [ ] Preventive Action: [ ] Improvement: Responsible: Date:
6. Follow-up on Implementation of Action: [ ] Satisfactory [ ] Not satisfactory (issue new NCPAR) Remarks: _____ Name & Signature: Date:
7. Verification on the effectiveness of action: (To be completed by the QMR or Dept. Head) [ ] Satisfactory (Close out) [ ] Not satisfactory (issue new NCPAR) Remarks: _____ Verified by: Date:

Republic of the Philippines
ROMBLON STATE UNIVERSITY
Odiongan, Romblon

Telephone No. (042) 567-5273/567-5859 *Telefax No. (042) 567-5270*

Effectivity Date: _____

Appendix B

CORRECTIVE AND ACTION MONITORING LOG

CPAR No.	Issued to: (Dept/Unit)	Date Issued	Date Due	Non-Conformance	Root Cause Analysis	Action Taken	Date Implemented	Date Verified Implemented	Date of Verified Effective	Status

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September 15, 2016

Reviewed by:

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Vice President for Academic Affairs
Quality Management Representative
Date: 17 February 2017

Approved by:

ARNULFO F. DE LUNA, PhD
Chairperson, Academic and Administrative Council
SUC President II

The RSU ACADEMIC and ADMINISTRATIVE COUNCIL
Resolution No: 90 series of 2017
Date: 24 February 2017