No. 5 Rin Telephon		E PHILIPPINE INC. a Mesa, Calamba City, Laguna o 69	INVESTIGATION REPORT FORM (IRF) Inhouse Detection			
Customer	SHIMADZU		Attention To	Mr Gerald De Guzmar	1	
Item Code	321-73954-11		Department PRODUCTION			
Item Description	ACCESSORY	BOX SUPPORT, AP	Date of Detection			
Job Order Number	WO-20-R-262-	9	Section Detected	Section Detected OQA		
The second second	ILLUSTRATION OF	THE PROBLEM	Major		Minor	
	1 CONTROL OF THE PROPERTY OF T		Lot Quantity (pcs 126 Nature of Defect:	Reject Quantity (pc 126 WRONG ACTUAL VS.	100.00%	
	ACTUAL ITE	M: 321-73954-01	Requirement:			
18 8 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	REQUIREMENT	: 321-73954-11	Actual:	Actual item and label shou		
NO. OF OCCU	RRENCE	DISPOSITION	AREA OF C	OCCURRENCE / ORIGIN	CONTENT	
First		Hold	Slotter	Gluing	Material	
Recurrence		Special Acceptance	EQOS	Vertical	Dimension	
No.:		For Rework	Diecut	Others:	Appearance	
Date:		Reject / Disposal	Detaching	PACKING	_ Process / Method	
Issued	by ·	Checked by	Approv	ved by	Received by (Receiving Section)	
Adrian Ve QA-IE S		Ms. Noemi Cepeda QA Supervisor	Mr. Reke QA-Asst. I	Almario Manager	Mr. Gerald De Guzman Heady Supervisor	
DIRECT AND		<u>inganta wakania katawa ka 1222 wa 1</u>	TION / ANALYSIS			
	: (Analyze the reaso	n of occurrence, why it happened?)		NUSE: (Analyze the reason of o	occurrence, why it leaked?)	
Why 1: Why 2: Why 3: Why 4: Why 5:			Why 1: Why 2: Why 3: Why 4: Why 5:	N/A		
Why 1: Sbuilloo L Why 2: Why 3: Why 4: Why 5:	p	/ _A	Why 1: Why 2: Why 3: Why 4: Why 5:	N/A		
Why 1: Why 2: Why 3: Why 4: Why 5:	PLS- S	EE ATTACHED	Why 1: Why 2: Why 3: Why 4: Why 5:	PLS. SEE AT	TAGUED	

KANEPACKAGE PHILIPPINE INC.

No. 5 Ring Road LISP II, Brgy. La Mesa, Calamba City, Laguna Telephone No. (049) 545-7166 to 69 Fax No. (049) 545-6302

INVESTIGATION REPORT FORM (IRF)

				FINAL CO	CLUSION			
OCCURRENCE ROOTCAUSE					OUTFLOW ROOTCAUSE			
- WRONG BLADE ISSUED BY TOOLING					- OPERATOR NOT CHECKTHE ACTUAL YS. DRAWING DURING TRUAL PON			
IMMEDIA	ATE ACTION: (Action to be don	e to contain/ temporary	correct the pr	oblem found).	CORRECTIVI	E ACTION: (Actions to be done to ensure that the problem will	I not happen again)	
A. Sorting Res	sult				Actions to be done to eliminate recurrence Who / When			
	Location	Total Stock	NG	Total Good		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	6.50	
RM	N/A					N/A		
WIP	N/A			The second secon	System			
FG	N/A							
B. Orientation								
Date	1 W 1 1 W 1 1 Mile 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				Design /	A1/.		
TITLE ORIENTATION DEGRADING WRONG ITEM OF SHIMADZU 321- 73954- II ACCESSORY BOX SUPPORT, AP					Tools	N/A		
ees	1 ees TOOLING, DETACHING, & DIE-CUT OPERATORS							
C. Reworking				•				
Rework Quan	tity	N/A				01.50		
Total Good N/A				Process	PLS. SEE ATTACHED	2		
Rework Perce	entage (Good)	A/A						
II. QA R	ROOTCAUSE VERIFICATIO	N (To be filled ou	t by QA In-o	charge)	Date Conducted:	2011 16 PIC: A. Yexgara		
Identified Rootcause				Recommendation				
Wrong attachment of labels, because the item Produced were wrong, since the diecul blade isgued is not correct.								
		III. CORREC	TIVE ACTIO	N VERIFICATIO	N (To be filled o	ut by QA In-charge)		

III. CORRECTIVE ACTION VERIFICATION (To be filled out by QA In-charge)						
	Checked by	Date	Implemented?	Remarks		
1st Verification of Action	A vergara	20 11 19	[/]Yes []No	C.A. is implemented		
2nd Verification of Action			[]Yes []No			
3rd Verification of Action			[]Yes []No			
Effectiveness of Action	A. Vergara	210117	[/]Yes []No	C.A. is effective		

Note: If no same defects / problems occurs for 5 consecutive deliveries, corrective action is considered effective / closed. If the same problem occurs within 5 consecutive deliveries or 3rd verification of action still not yet implemented, Investigation Report shall be re-issued to the affected department to provide new improvement action.

WALKE WALKER WANKER WAN	IV, CLOSURE		
SUPER DEPART	Approved by.	Process Owner Acknowledgment (Receiving 6)	ection)
Still Chen Re-liss DATE AND	QA supervisor QA Assobate. Q16414 Date:	Manager Line Leader Date: 210414 Date: 210414	s ad

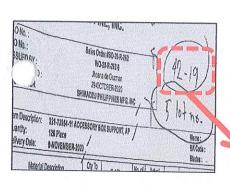
INVESTIGATION REPORT FOR WRONG ITEM OF SHIMADZU 321-73954-11 ACCESSORY BOX SUPPORT, AP

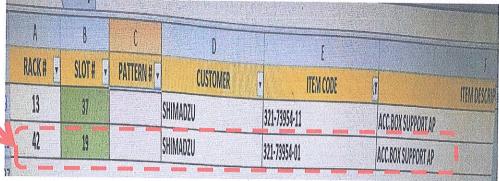
W1- Tooling custodian picked a wrong die-blade.

DIRECT CAUSE PROCESS/MATERIAL

 $\mathbf{W2}$ - During Searching/filtering of item needed in the Master list, he did not finish the typing of item code until the end number.

 $\mathbf{W3} ext{-}$ Two item code appears in monitor and he got misslook and pick the 321-73954-01.





(OUTFLOW) PROCESS/MATERIAL

W1- Because this item is existing during trial run Diecut operator check only the cutting condition of die-blade and the visual appearance.

W2- Both Diecut and Detaching operator not check the actual vs. drawing during trial run.

PRODUCTION CORRECTIVE ACTION

- Issue NTE to concern person.
- Orient the tooling custodian that during searching/filtering of tooling needed strictly finish the typing of item code.
- Re-orient the Diecut and Detaching operator regarding actual vs. drawing checking during trial run and check the actual blade condition by checking actual output during trial run. Assessment will indicate in the "REMARKS" portion of the Job Order.

PIC:

PRODUCTION

TARGET DATE:

201119

PREPARED BY:

GERALD DE GUZMAN PRODASST SUPERVISOR APPROVED BY:

WEENA V. APALLA SR. SUPERVISOR