

DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE FOOD AND DRUG ADMINISTRATION <b>BLOOD ESTABLISHMENT REGISTRATION AND PRODUCT LISTING</b>	<b>1. REGISTRATION NUMBER</b> FEI: 1174694 CFN: 1174694 <b>2. U.S. LICENSE NUMBER</b> 1731	<b>3. REASON FOR SUBMISSION</b> .1 <input checked="" type="checkbox"/> ANNUAL REGISTRATION .2 <input type="checkbox"/> INITIAL REGISTRATION .3 <input type="checkbox"/> CHANGE IN INFORMATION	FOR FDA USE ONLY <span style="float: right;">1</span>  DISTRICT OFFICE: Baltimore VALIDATED BY FDA: 07-DEC-2015 PRINTED BY FDA: 22-DEC-2015
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PLEASE READ INSTRUCTIONS CAREFULLY. Be sure to indicate any changes in your legal name or actual location in item 4, and any changes in your mailing address in item 6. Print all entries and make all corrections in red ink, if possible. Enter your phone number in item 8.3 and the phone number of your actual location in item 4.1. Sign the form and return to FDA. After validation, you will receive your Official Registration for the ensuing year.

This form is authorized by Sections 510(b), (j) and 704 of the Federal Food, Drug, and Cosmetic Act (Title 21, United States Code 360(b), (j) and 374). Failure to report this information is a violation of Section 301(f) and (p) of the Act (Title 21, United States Code 331(f) and (p)) and can result in a fine of up to \$1,000 or imprisonment up to one year or both, pursuant to Section 303(a) of the Act (Title 21, United States Code 33.3(a)).

**ENTER ALL CHANGES IN RED INK AND CIRCLE.**

**4. LEGAL NAME AND LOCATION** (Include legal name, number and street, city, state, country, and post office code)

NIH Clinical Center  
 10 Center Drive  
 Bldg. 10, Rm. 1C711A MSC 1184  
 Bethesda, MD 20892-1184

4.1 PHONE 301-496-4506

**5. OTHER NAMES USED AT THIS LOCATION** (Include trade name, doing-business-as, previous names, and other firms co-located. If applicable, include registration number.)

NIH Clinical Center

**6. MAILING ADDRESS OF REPORTING OFFICIAL** (Include institution name if applicable, number and street, city, state, country, and post office code)

NIH Clinical Center  
 ATTN: James W. Atkins  
 Dept of Transfusion Medicine  
 10 Center Dr, Bldg 10 MSC 1184  
 Rm 1C/711  
 Bethesda, MD 20892-1184

**7. U.S. AGENT** (Include name, institution name if applicable, number and street, city, state, and zip code)

7.1 E-MAIL ADDRESS

7.2 PHONE

**8. REPORTING OFFICIAL'S SIGNATURE**

8.1 TYPED NAME James W. Atkins  
 8.2 E-MAIL ADDRESS jatkins@cc.nih.gov  
 8.3 PHONE 301-402-1704

8.4 DATE

**9. TYPE OF OWNERSHIP**

- .1  SINGLE PROPRIETORSHIP
- .2  PARTNERSHIP
- .3  CORPORATION profit\_\_\_ non-profit\_\_\_
- .4  COOPERATIVE ASSOCIATION
- .5  FEDERAL (non-military)
- .6  U.S. MILITARY
- .7  STATE
- .8  COUNTY/MUNICIPAL/HOSPITAL AUTHORITY
- .9  OTHER (Specify) : \_\_\_\_\_

**10. TYPE ESTABLISHMENT** (Check all boxes that describe routine or autologous operations.)

- .1  COMMUNITY (NON-HOSPITAL) BLOOD BANK
- .2  HOSPITAL BLOOD BANK
- .3  PLASMAPHERESIS CENTER
- .4  PRODUCT TESTING LABORATORY
  - a. \_\_\_ INDEPENDENT
  - \_\_\_ ASSOCIATED W/ COMMUNITY or HOSPITAL BLOOD BANK
- .5  HOSPITAL TRANSFUSION SERVICE
  - a. \_\_\_ APPROVED FOR MEDICARE REIMBURSEMENT
  - \_\_\_ NOT APPROVED FOR MEDICARE REIMBURSEMENT
- .6  COMPONENT PREPARATION FACILITY
- .7  COLLECTION FACILITY
- .8  DISTRIBUTION CENTER
- .9  BROKER/WAREHOUSE
- .10  OTHER (Specify) : \_\_\_\_\_

U.S. LICENSE NUMBER OF PARENT FIRM \_\_\_\_\_

**11. PRODUCTS**

	COLLECT	MANUAL APHERESIS	AUTOMATED APHERESIS	PREPARE	LEUKOCYTES REDUCED	IRRADIATED	DONOR RETESTED	TEST	STORE and DISTRIBUTE to OTHERS
	(.1)	(.2)	(.3)	(.4)	(.5)	(.6)	(.7)	(.8)	(.9)
<input checked="" type="checkbox"/> ALLOGENEIC <input checked="" type="checkbox"/> AUTOLOGOUS <input checked="" type="checkbox"/> DIRECTED									
WHOLE BLOOD	1	<b>X</b>						<b>X</b>	
RED BLOOD CELLS (RBC)	2		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	
RBC FROZEN	3			<b>X</b>	<b>X</b>			<b>X</b>	
RBC DEGLYCEROLIZED	4			<b>X</b>	<b>X</b>	<b>X</b>			
RBC REJUVENATED	5								
RBC REJUVENATED FROZEN	6								
RBC REJUVENATED DEGLYCEROLIZED	7								
CRYOPRECIPITATED AHF	8			<b>X</b>					
PLATELETS	9		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>			
LEUKOCYTES/GRANULOCYTES	10		<b>X</b>	<b>X</b>		<b>X</b>		<b>X</b>	
PLASMA	11			<b>X</b>					
PLASMA CRYOPRECIPITATE REDUCED	12								
FRESH FROZEN PLASMA	13		<b>X</b>	<b>X</b>					
LIQUID PLASMA	14								
THERAPEUTIC EXCHANGE PLASMA	15								
SOURCE LEUKOCYTES	16								
SOURCE PLASMA	17								
RECOVERED PLASMA	18								
BLOOD PRODUCTS FOR DIAGNOSTIC USE	19								
BLOOD BANK REAGENTS	20								
OTHER	21								