

For Comprehensive Tissue Procurement Services/Tissue Processing Facilities/  
 Tissue Storage Facilities

**PART I** (Please print or type)

A. Type of Service

(check all that apply)

- Comprehensive Tissue Procurement Service
- Tissue Processing Facility
- Tissue Storage Facility

B. Activities Performed

(check all that apply)

- Donor solicitation
- Donor selection
- Tissue harvesting
- Tissue processing
- Tissue storage
- Tissue transplantation-transfer

C. Tissue bank director (must meet requirements of 10 NYCRR 52-2.5(a)(2)) or 58-5.2(e)), as applicable

Name			
Name of bank or site			
Business address			
City	State	Zip	Telephone (    )
Days and hours present on site			

Attach resume or curriculum vitae, specifically identifying all other employment.

D. Medical director (if different from tissue bank director). Must meet requirements of 52-2.5(a)(3) or 58-5.2(f), as applicable.

Name			
Name of bank or site			
Business address			
City	State	Zip	Telephone (    )
License number of medical director			State where issued
Days and hours present on site			

Attach resume or curriculum vitae, specifically identifying all other employment.

**PART II – MEDICAL ADVISORY COMMITTEE****(Please print or type)**

List all medical advisory committee members, including area of expertise, pertinent positions held and location of employment. (Attach additional sheets if necessary.) Membership must include expertise in microbiology, clinical pathology or infectious disease. Facilities collecting reproductive tissue from donors must list a qualified geneticist.

Name	Area of Expertise/Position Held	Location of Primary Employment

**PART III – DONOR SELECTION AND TESTING****(Please print or type)**

A. Attach copies of donor health history forms, consent forms and applicable donor selection criteria and protocols.

B. List all laboratory tests performed on donors or donated tissue and indicate site of testing. If tests are performed at the applicant bank, indicate "on-site." (Attach additional sheets if necessary.)

Analyte/condition	Reference Laboratory Name and Address		
	Name		
	Street		
	City	State	Zip
	Name		
	Street		
	City	State	Zip
	Name		
	Street		
	City	State	Zip
	Name		
	Street		
	City	State	Zip
	Name		
	Street		
	City	State	Zip

For any bank or testing laboratory located in New York State, supply a copy of the NYS permit held by the laboratory providing clinical laboratory testing services. The permit must specify approval for donor testing.

For tissue banks located outside of New York State, supply a copy of the CLIA certificate and, where required, the state license.

Each document supplied must specify all categories for which licensure has been granted.

A. Description of Premises

1. Is the space contiguous?  Yes  No If not, please indicate other location(s).

2. What is the total approximate square footage of the work space? \_\_\_\_\_

3. Is the tissue bank physically located within the space occupied by any other health service purveyor?

Yes  No If yes, please explain.

B. Equipment

List and briefly describe equipment used; attach additional sheets, if necessary.

**PART V**

(Please print or type)

A. Describe the tissue bank's proposed or existing service areas for the acquisition and/or distribution of tissue.

B. Attach a complete list of all tissue banks that provide tissue to the applicant, including limited and comprehensive tissue procurement services, tissue processing facilities and tissue storage facilities. Indicate "NA" if not applicable.

C. Attach a complete list of all sites in New York State to which tissues are distributed by the applicant, including tissue processing facilities, tissue storage facilities, tissue transplantation facilities and insemination/implantation sites. Indicate "NA" if not applicable.

D. Attach a copy of all existing tissue acquisition and/or processing agreements. Indicate "NA" if not applicable.

E. Attach a brief description of any educational programs provided by the tissue bank, including those programs designed to encourage tissue donation. Indicate "NA" if not applicable.

**PART VI**

\_\_\_\_\_  
Tissue Bank Director's Name                      Tissue Bank Director's Signature                      m / d / y

\_\_\_\_\_  
Medical Director's Name                      Medical Director's Signature                      m / d / y