

## PART I - Facility and Contact Information

Name of Facility			
Doing Business As (Optional)			
New York State Tissue Bank Facility Identification Number			
Street Address			
Street Address			
City	State	Zip	County
Telephone	Fax		
Contact E-Mail Address(es)			

Mailing address (if different from above):

## PART II – Director

Director's First Name	Middle Name		
Last Name	Date of Birth		
Title			
Work Address			
City	State	Zip	Office Telephone
Fax	E-mail Address		
Does the Director have an existing HCS account?	Yes	No	If "Yes", Director's HCS ID

<p>For Tissue Resources Program use only</p> <p><input type="checkbox"/> New Application</p> <p><input type="checkbox"/> Amended Application</p> <p>Facility ID _____</p> <p>Date Received _____</p>
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**PART III – Annual Gestational Surrogacy Procedures**

A. Provide the estimated annual number of gestational surrogacy procedures:

IVF	Embryo Transfer
Gamete Intrafallopian Transfer	Other

**PART IV – Signature**

Providing false or misleading information in this statement may lead to prosecution under applicable federal or state laws and may result in denial of the New York State Department of Health Tissue Resources Program Application for Licensure.

I hereby affirm under penalty of perjury that the information provided on this form and all attachments is true to the best of my knowledge and belief.

\_\_\_\_\_  
Name of Authorized Representative Title

\_\_\_\_\_  
Phone Number E-mail Address

\_\_\_\_\_  
Signature Date

**The completed application, additional required forms, and supporting documentation must be submitted to the New York State Department of Health Tissue Resources Program.**

**By e-mail as a pdf (preferred) to:** [tissue@health.ny.gov](mailto:tissue@health.ny.gov)

**By mail to:** Tissue Resources Program  
Wadsworth Center  
New York State Department of Health  
Empire State Plaza  
Albany, NY 12237