

PART I - ACTIVITIES PERFORMED

Current New York State tissue bank facility ID #, if applicable: _____

No changes to this section from current license.

Place a checkmark in applicable boxes below to indicate the activities performed.

Donor Source	Donor Selection	Refer Potential Donors	Provide Staff for Tissue Acquisition	Provide Facilities or Equipment for Tissue Acquisition
Reproductive Tissue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematopoietic Progenitor Cells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Tissues (List all)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART II - EQUIPMENT

No changes to this section from current license.

Provide a brief description of equipment used (Attach additional pages if necessary).

PART III - ADMINISTRATIVE RESPONSIBILITY

No changes to this section from current license.

Director or other person with primary responsibility for compliance with New York State Department of Health requirements.

Name			
Title			
Facility Name			
Facility Address			
City	State	ZIP	Telephone
Days and hours present on site		E-mail Address	

Signature of Director or other person with primary responsibility for compliance: _____

Date: _____

PART IV – COMPREHENSIVE TISSUE PROCUREMENT SERVICE PARTNERS

No changes to this section from current license.

Indicate the New York State-licensed comprehensive tissue procurement service(s) that performs donor qualification and selection and/or recovery and collection activities by agreement with your facility
(Submit additional sheets, if necessary).

Facility Name	NYS Facility ID#		
Facility Address			
City	State	ZIP	Phone

Facility Name	NYS Facility ID#		
Facility Address			
City	State	ZIP	Phone

Facility Name	NYS Facility ID#		
Facility Address			
City	State	ZIP	Phone

Facility Name	NYS Facility ID#		
Facility Address			
City	State	ZIP	Phone

Facility Name	NYS Facility ID#		
Facility Address			
City	State	ZIP	Phone

PART V – SIGNATURE

Name of person completing form: _____

Title: _____

Signature: _____ Date: _____