NEW YORK STATE DEPARTMENT OF HEALTH
Tissue Resources Program

Application for ARTSP Registration

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

A. For a Director who already has an HCS account:

Director's Name
Director's HCS Account Number

B. For a Director who does not have an HCS account:

Director's First Name	Middle Name		
Last Name	Month and Day of Birth		
Title			
Work Address			
City	State	Zip	Office Telephone
Fax	E-Mail Address		

For Tissue Resources Program use only

☐ New Application
☐ Amended Application

Facility ID _____

Date Received _____

PART III – Ova Donor Coordinator

An Ova Donor Coordinator is any staff member who will need access to the Ova Donor Registry.

A. For Ova Donor Coordinators who already have HCS accounts:

Coordinator's Name
HCS Account Number

Coordinator's Name
HCS Account Number

Coordinator's Name
HCS Account Number

B. For Ova Donor Coordinators who do not have HCS accounts:

Coordinator's First Name	Middle Name
Last Name	Month and Day of Birth
Office Telephone	E-Mail Address

Coordinator's First Name	Middle Name
Last Name	Month and Day of Birth
Office Telephone	E-Mail Address

Coordinator's First Name	Middle Name
Last Name	Month and Day of Birth
Office Telephone	E-Mail Address

PART IV – Annual Gestational Surrogacy Procedures

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

IVF	Embryo Transfer
Gamete Intrafallopian Transfer	Other

PART V – 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

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