


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: 3012052149 CFN: <b>2. U.S. LICENSE NUMBER</b> 747	<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  DISTRICT OFFICE: New Orleans VALIDATED BY FDA: 22-DEC-2016 PRINTED BY FDA: 22-DEC-2016																																																																																																																																																																																																																																						
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.																																																																																																																																																																																																																																									
<b>ENTER ALL CHANGES IN RED INK AND CIRCLE.</b> <b>4. LEGAL NAME AND LOCATION</b> (Include legal name, number and street, city, state, country, and post office code)  Blood Assurance, Inc. Blood Assurance, Inc. Columbia Donor Center 1412 Trotwood Avenue Suite 69 Columbia, TN 38401  4.1 PHONE 931-548-8801	<b>9. TYPE OF OWNERSHIP</b> .1 <input type="checkbox"/> SINGLE PROPRIETORSHIP .2 <input type="checkbox"/> PARTNERSHIP .3 <input checked="" type="checkbox"/> CORPORATION profit___ non-profit <input checked="" type="checkbox"/> .4 <input type="checkbox"/> COOPERATIVE ASSOCIATION .5 <input type="checkbox"/> FEDERAL (non-military) .6 <input type="checkbox"/> U.S. MILITARY .7 <input type="checkbox"/> STATE .8 <input type="checkbox"/> COUNTY/MUNICIPAL/HOSPITAL AUTHORITY .9 <input type="checkbox"/> OTHER (Specify) : _____	<b>10. TYPE ESTABLISHMENT</b> (Check all boxes that describe routine or autologous operations.) .1 <input type="checkbox"/> COMMUNITY (NON-HOSPITAL) BLOOD BANK .2 <input type="checkbox"/> HOSPITAL BLOOD BANK .3 <input type="checkbox"/> PLASMAPHERESIS CENTER .4 <input type="checkbox"/> PRODUCT TESTING LABORATORY a. ___ INDEPENDENT ___ ASSOCIATED W/ COMMUNITY or HOSPITAL BLOOD BANK .5 <input type="checkbox"/> HOSPITAL TRANSFUSION SERVICE a. ___ APPROVED FOR MEDICARE REIMBURSEMENT ___ NOT APPROVED FOR MEDICARE REIMBURSEMENT .6 <input type="checkbox"/> COMPONENT PREPARATION FACILITY .7 <input checked="" type="checkbox"/> COLLECTION FACILITY .8 <input checked="" type="checkbox"/> DISTRIBUTION CENTER .9 <input type="checkbox"/> BROKER/WAREHOUSE .10 <input type="checkbox"/> OTHER (Specify) : _____  } 747 U.S. LICENSE NUMBER OF PARENT FIRM																																																																																																																																																																																																																																							
<b>5. OTHER NAMES USED AT THIS LOCATION</b> (Include trade name, doing-business-as, previous names, and other firms co-located. If applicable, include registration number.)	<b>11. PRODUCTS</b> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:55%;"></th> <th style="width:5%;">COLLECT</th> <th style="width:5%;">MANUAL APHERESIS</th> <th style="width:5%;">AUTOMATED APHERESIS</th> <th style="width:5%;">PREPARE</th> <th style="width:5%;">LEUKOCYTES REDUCED</th> <th style="width:5%;">IRRADIATED</th> <th style="width:5%;">DONOR RETESTED</th> <th style="width:5%;">TEST</th> <th style="width:5%;">STORE and DISTRIBUTE to OTHERS</th> </tr> <tr> <th style="text-align: center;"> <input checked="" type="checkbox"/> ALLOGENEIC                                <input checked="" type="checkbox"/> AUTOLOGOUS                                <input checked="" type="checkbox"/> DIRECTED                         </th> <th style="text-align: center;">(1)</th> <th style="text-align: center;">(2)</th> <th style="text-align: center;">(3)</th> <th style="text-align: center;">(4)</th> <th style="text-align: center;">(5)</th> <th style="text-align: 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<b>6. MAILING ADDRESS OF REPORTING OFFICIAL</b> (Include institution name if applicable, number and street, city, state, country, and post office code)  Blood Assurance, Inc. ATTN: Denise E. Burke 705 E 4th St Chattanooga, TN 37403	<b>7. U.S. AGENT</b> (Include name, institution name if applicable, number and street, city, state, and zip code)																																																																																																																																																																																																																																								
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