

DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE FOOD AND DRUG ADMINISTRATION ESTABLISHMENT REGISTRATION AND LISTING FOR HUMAN CELLS, TISSUES, AND CELLULAR AND TISSUE-BASED PRODUCTS (HCT/PS) <i>(See reverse side for instructions)</i>	1. REGISTRATION NUMBER (Field Establishment Identifier) FEI: 3001238554	2. REASON FOR SUBMISSION a. <input type="checkbox"/> INITIAL REGISTRATION / LISTING b. <input checked="" type="checkbox"/> ANNUAL REGISTRATION / LISTING c. <input type="checkbox"/> CHANGE IN INFORMATION d. <input type="checkbox"/> INACTIVE	VALIDATION--FOR FDA USE ONLY 1 VALIDATED BY FDA:08-DEC-2011 DISTRICT: San Francisco PRINTED BY FDA:15-DEC-2011
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION														
3. OTHER FDA REGISTRATIONS	10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps	Establishment Functions									11. HCT/PS DESCRIBED IN 21 CFR 1271.10	12. HCT/PS REGULATED AS MEDICAL DEVICES	13. HCT/PS REGULATED AS DRUGS OR BIOLOGICAL DRUGS	14. PROPRIETARY NAME(S)	
a. BLOOD FDA 2830 NO. _____ b. DEVICES FDA 2891 NO. _____ c. DRUG FDA 2656 NO. _____	Types of HCT / Ps	Recover	Screen	Test	Package	Process	Store	Label	Distribute						
4. PHYSICAL LOCATION <i>(Include legal name, number and street, city, state, country, and post office code)</i> Community Blood Center dba Community Tissue Services 7100 N. Financial Drive, Suite 105 Fresno, California 93720 a. PHONE 559-224-1168 EXT _____ b. <input type="checkbox"/> SATELLITE RECOVERY ESTABLISHMENT (MANUFACTURING ESTABLISHMENT FEI NO. _____) c. <input type="checkbox"/> TESTING FOR MICRO-ORGANISMS ONLY	a. Bone						X	X	X	X					
	b. Cartilage						X	X	X	X					
	c. Cornea														
	d. Dura Mater														
	e. Embryo <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous														
	f. Fascia						X	X	X	X					
5. ENTER CORRECTIONS TO ITEM 4	g. Heart Valve														
	h. Ligament						X	X	X	X					
	i. Oocyte <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous														
	j. Pericardium						X	X	X	X					
	k. Peripheral Blood Stem Cells <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic														
	l. Sclera														
6. MAILING ADDRESS OF REPORTING OFFICIAL <i>(Include institution name if applicable, number and street, city, state, country, and post office code)</i> Community Blood Center dba Community Tissue Services Attn: David M. Smith, MD 349 S. Main Street Dayton, Ohio 45402-2715 a. PHONE 937-461-3450 EXT 3610	m. Semen <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous														
	n. Skin						X	X	X	X					
7. ENTER CORRECTIONS TO ITEM 6 b. PHONE _____	o. Somatic Cell Therapy Products <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic														
	p. Tendon						X	X	X	X					
8. U.S. AGENT a. E-MAIL _____	q. Umbilical Cord Blood Stem Cells <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic														
	r. Vascular Graft														
9. REPORTING OFFICIAL'S SIGNATURE a. TYPED NAME David M. Smith, MD b. E-MAIL dsmith@cbccts.org c. TITLE CEO d. DATE 07-DEC-2011	s. Parathyroid						X		X	X					
	t. Peritoneal Membrane						X	X	X	X					
	u.														
	v.														