CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE SYSTEM BRANCH, HEALTH SYSTEMS REGULATION
410 CAPITOL AVE., MS#12HSR, P.O. BOX 340308, HARTFORD, CT 06134-0308, TEL: 860 509-7400

APPLICATION FOR REGISTRATION OF A PLASMAPHERESIS CENTER AND/OR BLOOD COLLECTION FACILITY

REV. 8/19/2005

Office Use Only: Blood Bank Registration No. BB- __________; Date Received: _______

1. CENTER, FACILITY or BLOOD BANK NAME:

2. ADDRESS: _____
   Number & Street　　City　　_____ State　　_____ Zip Code

3. TELEPHONE NUMBER:　　FAX #:　　E-Mail:

4. NAME OF DIRECTOR:　　CT License No.

5. NAME OF REGISTRANT: _____
   "Registrant" means the person in whose name the registration is granted. The registrant shall be the owner, if the center is owned by a single individual, or a responsible officer or representative when the center is owned by a group, partnership, firm, corporation, or governmental agency.

6. FACILITY TYPE: (Check all that apply.)

   ☐ **Plasmapheresis and / or Plateletpheresis.**
   ☐ **Blood Collection Facility** (Collection for administering blood / components to any human being).
   ☐ Homologous　☐ Autologous　☐ Directed Donors　☐ Therapeutic.
   ☐ **General Blood Bank Procedures:**
   ☐ ABO Group & RH Type　☐ Antibody Detection (Transfusion);
   ☐ Antibody Identification　☐ Compatibility Testing　☐ Other; infectious disease testing.

7. ACCREDITATION: The blood bank is accredited by the American Association of Blood Banks:
   Yes: ☐ ; No: ☐ .

8. OWNERSHIP:
   ☐ Sole Proprietorship　☐ Partnership　☐ Other (Specify):
   ☐ Corporation (profit)　☐ Corporation (nonprofit)
   If sole proprietorship, partnership or other, list name and address of owner below. If a corporation, list name of corporation, directors and officers.

   Corporation:
   Name　　Address

   Directors / Officers:
   Name　　_____ Title

9. DAYS AND HOURS OF OPERATION: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Th. ☐ Fri. ☐ Sat. ☐ Sun.
☐ Day Shift ☐ Evening Shift ☐ Night Shift ☐ 24 Hrs./Day, 7 Days/Wk.

10. HOURS OF SUPERVISOR(S):
☐ Day Shift ☐ Evening Shift ☐ Night Shift ☐ Coverage 24 Hrs./Day, 7 Days/Wk.

11. BLOOD BANK LABORATORY / CENTER DIRECTOR QUALIFICATIONS:
The director is a physician licensed to practice medicine in Connecticut who is:
- ☐ board certified in clinical pathology, or
- ☐ board certified in blood banking by the American Board of Pathology; or
- ☐ received a minimum of one year of specialized training in blood banking, or
- ☐ has equivalent experience and training acceptable to the department.

12. Blood Bank Laboratory General Supervisor (person who supervises daily quality control and patient testing).

Name Degree / Certification

13. Number of Personnel Employed:
_____ M.D.; _____ Ph.D. / D. Sc.; _____ M.S.; _____ BA / BS with MT Registration
_____ BA / BS without MT Registration; _____ AA / AS; _____ Technical personnel without degrees.

14. The director is present and in active direction of the center at least one-half of its normal working hours each week (or a minimum of 15 working hours)? ☐ Yes ☐ No.

15. Plasmapheresis is not performed except when a physician licensed to practice in Connecticut is on the premises?
☐ Yes ☐ No ☐ NA

16. If this is a renewal application for an existing registration, application is made: (check all that apply)
☐ prior to expiration of current registration ☐ before any change in ownership or director;
☐ prior to major expansion or alteration in quarters ☐ prior to removal of the center to new quarters.

17. Reference Laboratories within Connecticut (Name, Address, CLIA Number).

18. Reference Laboratories outside Connecticut (Name, Address, CLIA Number).

19. A list of all additional blood collection facilities in permanent locations is attached? ☐ Yes ☐ No ☐ NA

20. The facility has written approval from the department for a program of mobile or permanently fixed collection stations? ☐ Yes ☐ No ☐ NA

We, the undersigned, individually and jointly certify that the information provided in this application is to the best of our knowledge and belief accurate and correct.

If registration and laboratory approval is granted to this center / blood collection facility by the Commissioner of Health, we agree to comply fully with all statutes and regulations by the State of Connecticut and directives pursuant thereto that may be issued by the Commissioner of Health or his/her representatives.

We fully understand that the Commissioner of Health may at any time revoke or suspend the registration of this center / blood collection facility or certificate of approval, if in his/her opinion, the center / blood collection facility has violated any statutes, regulations, or directives pursuant thereto, or if the continued operation of the center / blood collection facility is deemed prejudicial to the public health.

In witness whereof, we have hereunto set our hands and seal this

________ day of _________________, 20 ____.

______________________________	______________________________
Name of Director (print)	Name of Registrant (print)
______________________________	______________________________
Signature of Director	**Signature of Registrant**

State of ____________________________

County of ____________________________

Personally appeared before me duly qualified to administer oaths and subscribed and made oath to the truth of the foregoing affidavit.

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Signature of Notary Public

______________________________	______________________________
Notary Public (Print Name)	Date My Commission Expires