State of Illinois
Division of Health Care Facilities
and Programs
525 W. Jefferson St., Fourth
Floor Springfield, IL 62761
Ph: (217) 782-6747
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ILLINOIS

TISSUE AND SPERM BANK REGISTRATION

Registration Number _____

New Application? ☐

Change(s): ☐ **None** ☐ **Director** ☐ **Facility Name** ☐ **Address** ☐ **Ownership** ☐ **Other: _____**

1) Name of Facility Director or Manager _____ New Directors, Managers or first time registration, please include a brief curriculum vitae and copy of academic degree.

2) Facility Name _____

Address _____

City _____ State _____ ZIP Code _____

Telephone _____ Fax _____ E-mail _____

3) Facility Specialty(s): ☐ **Musculoskeletal** ☐ **Skin** ☐ **Reproductive** ☐ **Sperm Bank** ☐ **Tissue Bank**
☐ **Other (cells, tissue, organs, etc.): _____**

4) Name and address of entity operating the sperm or tissue bank, if different from above.

Name _____Address _____

City _____ State _____ ZIP Code _____ Telephone _____

5) If applicable, include a list of addresses and phone number utilized in operating the sperm or tissue bank.

6) Include a description of services provided (attach additional information if more space is required)
_____
_____
_____

7) Is your sperm or tissue bank registered with the FDA? ☐ **Yes** ☐ **No If not, explain _____**
_____
_____

8) Accreditation information: ☐ **AATB** ☐ **CAP** ☐ **COLA** ☐ **JCAHO** ☐ **N/A OTHER _____**

9) Date of last FDA on-site inspection _____ Date of last Accredited on-site inspection _____

Is the facility in compliance? _____ if not, explain _____
_____
_____

10) Is the sperm or tissue tested for "relevant communicable diseases?" Explain below.
_____
_____
_____

11) ***Certification and Signature:*** *Under penalty of perjury, I certify the information provided herein is correct. I understand that misrepresentation will be cause for removal from the state of Illinois Sperm and Tissue Bank registration files, and subject to fines and other penalties allowed by the law.*

12) Signature _____ Date _____
(Facility Director)