



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)