



**HEALTH CARE FACILITIES AND PROGRAMS  
TISSUE AND SPERM BANK REGISTRATION**

Registration Number \_\_\_\_\_

Change(s):  None  Director  Facility Name  Address  Ownership  Other: \_\_\_\_\_

1) Director Name \_\_\_\_\_ NOTE: New lab directors 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)