

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) (See reverse side for instructions)	1. REGISTRATION NUMBER (FDA Establishment Identifier) FEI: 3000718784	2. REASON FOR SUBMISSION a. <input type="checkbox"/> INITIAL REGISTRATION / LISTING b. <input type="checkbox"/> ANNUAL REGISTRATION / LISTING c. <input checked="" type="checkbox"/> CHANGE IN INFORMATION d. <input type="checkbox"/> INACTIVE	VALIDATION--FOR FDA USE ONLY VALIDATED BY FDA:11-JAN-2018 DISTRICT: Cincinnati PRINTED BY FDA:27-JAN-2018
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION														14. PROPRIETARY NAME(S)		
3. OTHER FDA REGISTRATIONS	10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps									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					
	Types of HCT / Ps	Establishment Functions															
		Recover	Screen	Test	Package	Process	Store	Label	Distribute								
4. PHYSICAL LOCATION (Include legal name, number and street, city, state, country, and post office code) Community Blood Center dba Community Tissue Services 2736 N. Holland-Sylvania Road Toledo, Ohio 43615 a. PHONE 419-536-4924 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			X	X						
	b. Cartilage	X	X			X	X			X	X						
	c. Cornea	X	X									X					
	d. Dura Mater																
	e. Embryo <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous																
	f. Fascia	X	X			X	X			X	X						
	g. Heart Valve	X	X									X					
	h. Ligament	X	X			X	X			X	X						
	i. Oocyte <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous																
	j. Pericardium	X	X			X	X			X	X						
k. Peripheral Blood Stem <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic																	
l. Sclera	X	X									X						
m. Semen <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous																	
5. ENTER CORRECTIONS TO ITEM 4 6. MAILING ADDRESS OF REPORTING OFFICIAL (Include institution name if applicable, number and street, city, state, country, and post office code) Community Blood Center dba Community Tissue Services Attn: David M. Smith, MD 349 South Main Street Dayton, Ohio 45402-2715 a. PHONE 937-461-3450 EXT _____ b. PHONE _____	n. Skin	X	X			X	X			X	X						
	o. Somatic Cell Therapy Products <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic																
	p. Tendon	X	X			X	X			X	X						
q. Umbilical Cord Blood <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic																	
r. Vascular Graft	X	X									X						
7. ENTER CORRECTIONS TO ITEM 6 8. U.S. AGENT a. E-MAIL _____	s.																
	t.																
	u.																
	v.																
9. REPORTING OFFICIAL'S SIGNATURE a. TYPED NAME David M. Smith, MD b. E-MAIL pmalone@cbccts.org c. TITLE CEO d. DATE 11-JAN-2018																	