

DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE FOOD AND DRUG ADMINISTRATION <b>ESTABLISHMENT REGISTRATION AND LISTING FOR HUMAN CELLS, TISSUES,                  AND CELLULAR AND TISSUE-BASED PRODUCTS (HCT/Ps)</b> (See reverse side for instructions)	<b>1. REGISTRATION NUMBER</b> (FDA Establishment Identifier)  FEI: 3003140045	<b>2. REASON FOR SUBMISSION</b> a. <input type="checkbox"/> INITIAL REGISTRATION / LISTING b. <input checked="" type="checkbox"/> ANNUAL REGISTRATION / LISTING c. <input type="checkbox"/> CHANGE IN INFORMATION d. <input type="checkbox"/> INACTIVE	<b>VALIDATION--FOR FDA USE ONLY</b> VALIDATED BY FDA:16-NOV-2016 DISTRICT: Baltimore PRINTED BY FDA:15-DEC-2016
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION	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	14. PROPRIETARY NAME(S)																			
<b>3. OTHER FDA REGISTRATIONS</b> a. BLOOD FDA 2830 NO. _____ b. DEVICES FDA 2891 NO. _____ c. DRUG FDA 2656 NO. _____	<b>10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps</b> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width:30%;">Types of HCT / Ps</th> <th colspan="9" style="text-align: center;">Establishment Functions</th> </tr> <tr> <th style="width:5%;">Recover</th> <th style="width:5%;">Screen</th> <th style="width:5%;">Test</th> <th style="width:5%;">Package</th> <th style="width:5%;">Process</th> <th style="width:5%;">Store</th> <th style="width:5%;">Label</th> <th style="width:5%;">Distribute</th> <th style="width:5%;"></th> </tr> </thead> </table>					Types of HCT / Ps	Establishment Functions									Recover	Screen	Test	Package	Process	Store	Label	Distribute	
Types of HCT / Ps	Establishment Functions																							
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<b>4. PHYSICAL LOCATION</b> (Include legal name, number and street, city, state, country, and post office code) Genetics & IVF Institute  3015 Williams Drive 3rd Floor Fairfax, Virginia 22031  a. PHONE 703-698-7355 EXT _____ b. <input type="checkbox"/> SATELLITE RECOVERY ESTABLISHMENT (MANUFACTURING ESTABLISHMENT FEI NO. _____) c. <input type="checkbox"/> TESTING FOR MICRO-ORGANISMS ONLY	a. Bone b. Cartilage c. Cornea d. Dura Mater e. Embryo <input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous f. Fascia g. Heart Valve h. Ligament i. Oocyte <input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous j. Pericardium k. Peripheral Blood Stem <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic l. Sclera m. Semen <input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous n. Skin o. Somatic Cell Therapy Products <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic p. Tendon q. Umbilical Cord Blood <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic r. Vascular Graft																							
<b>5. ENTER CORRECTIONS TO ITEM 4</b>																								
<b>6. MAILING ADDRESS OF REPORTING OFFICIAL</b> (Include institution name if applicable, number and street, city, state, country, and post office code) Genetics & IVF Institute 3015 Williams Drive Attn: Cheryl Richardson Fairfax, Virginia 22031  a. PHONE 800-338-8407 EXT _____ b. PHONE _____																								
<b>7. ENTER CORRECTIONS TO ITEM 6</b>																								
<b>8. U.S. AGENT</b>  a. E-MAIL _____																								
<b>9. REPORTING OFFICIAL'S SIGNATURE</b>  a. TYPED NAME Megan Taylor b. E-MAIL mtaylor@givf.com c. TITLE Document Administrator d. DATE 15-NOV-2016	s. t. u. v.																							