

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION
BLOOD ESTABLISHMENT REGISTRATION AND PRODUCT LISTING

1. REGISTRATION NUMBER

FEI: 3007203928

CFN:

2. U.S. LICENSE NUMBER

3. REASON FOR SUBMISSION

- ANNUAL REGISTRATION
- INITIAL REGISTRATION
- CHANGE IN INFORMATION

FOR FDA USE ONLY



PLEASE READ INSTRUCTIONS CAREFULLY. Be sure to indicate any changes in your legal name or actual location in item 4, and any changes in your mailing address in item 6. Print all entries and make all corrections in red ink, if possible. Enter your phone number in item 8.3 and the phone number of your actual location in item 4.1. Sign the form and return to FDA. After validation, you will receive your Official Registration for the ensuing year.

This form is authorized by Sections 510(b), (j) and 704 of the Federal Food, Drug, and Cosmetic Act (Title 21, United States Code 360(b), (j) and 374). Failure to report this information is a violation of Section 301(f) and (p) of the Act (Title 21, United States Code 331(f) and (p)) and can result in a fine of up to \$1,000 or imprisonment up to one year or both, pursuant to Section 303(a) of the Act (Title 21, United States Code 333(a)).

DISTRICT OFFICE: Philadelphia
VALIDATED BY FDA: 21-DEC-2016
PRINTED BY FDA: 18-JAN-2017

ENTER ALL CHANGES IN RED INK AND CIRCLE.

4. LEGAL NAME AND LOCATION (Include legal name, number and street, city, state, country, and post office code)

LABS-Northeast
401 North 3rd Street
Suite 279
Philadelphia, PA 19123

4.1 PHONE 1-800-321-6088

5. OTHER NAMES USED AT THIS LOCATION (Include trade name, doing-business-as, previous names, and other firms co-located. If applicable, include registration number.)

9. TYPE OF OWNERSHIP

- SINGLE PROPRIETORSHIP
- PARTNERSHIP
- CORPORATION profit non-profit
- COOPERATIVE ASSOCIATION
- FEDERAL (non-military)
- U.S. MILITARY
- STATE
- COUNTY/MUNICIPAL/HOSPITAL AUTHORITY
- OTHER (Specify): _____

10. TYPE ESTABLISHMENT (Check all boxes that describe routine or autologous operations.)

- COMMUNITY (NON-HOSPITAL) BLOOD BANK
- HOSPITAL BLOOD BANK
- PLASMAPHERESIS CENTER
- PRODUCT TESTING LABORATORY
 - a. INDEPENDENT
 - ASSOCIATED W/ COMMUNITY or HOSPITAL BLOOD BANK
- HOSPITAL TRANSFUSION SERVICE
 - a. APPROVED FOR MEDICARE REIMBURSEMENT
 - NOT APPROVED FOR MEDICARE REIMBURSEMENT
- COMPONENT PREPARATION FACILITY
- COLLECTION FACILITY
- DISTRIBUTION CENTER
- BROKER/WAREHOUSE
- OTHER (Specify): _____

U.S. LICENSE NUMBER OF PARENT FIRM _____

11. PRODUCTS

	ALLOGENEIC	AUTOLOGOUS	DIRECTED	COLLECT (.1)	MANUAL APHERESIS (.2)	AUTOMATED APHERESIS (.3)	PREPARE (.4)	LEUKOCYTES REDUCED (.5)	IRRADIATED (.6)	DONOR RETESTED (.7)	TEST (.8)	STORE and DISTRIBUTE to OTHERS (.9)
WHOLE BLOOD				1							X	
RED BLOOD CELLS (RBC)				2							X	
RBC FROZEN				3							X	
RBC DEGLYCEROLIZED				4							X	
RBC REJUVENATED				5							X	
RBC REJUVENATED FROZEN				6							X	
RBC REJUVENATED DEGLYCEROLIZED				7							X	
CRYOPRECIPITATED AHF				8							X	
PLATELETS				9							X	
LEUKOCYTES/GRANULOCYTES				10							X	
PLASMA				11							X	
PLASMA CRYOPRECIPITATE REDUCED				12							X	
FRESH FROZEN PLASMA				13							X	
LIQUID PLASMA				14							X	
THERAPEUTIC EXCHANGE PLASMA				15							X	
SOURCE LEUKOCYTES				16							X	
SOURCE PLASMA				17							X	
RECOVERED PLASMA				18							X	
BLOOD PRODUCTS FOR DIAGNOSTIC USE				19							X	
BLOOD BANK REAGENTS				20							X	
OTHER				21							X	

6. MAILING ADDRESS OF REPORTING OFFICIAL (Include institution name if applicable, number and street, city, state, country, and post office code)

LABS-Northeast
ATTN: Ann V. Niedzinski
6933 South Revere Parkway
Centennial, CO 80112

7. U.S. AGENT (Include name, institution name if applicable, number and street, city, state, and zip code)

7.1 E-MAIL ADDRESS

7.2 PHONE

8. REPORTING OFFICIAL'S SIGNATURE

Ann V. Niedzinski

8.1 TYPED NAME Ann V. Niedzinski

8.2 E-MAIL ADDRESS ann_niedzinski@labs-inc.org

8.3 PHONE 720-528-4774

8.4 DATE