

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: 3001236615	2. REASON FOR SUBMISSION 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	VALIDATION--FOR FDA USE ONLY VALIDATED BY FDA:29-NOV-2016 DISTRICT: New Jersey PRINTED BY FDA:15-DEC-2016
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION	11. HCT/Ps DESCRIBED IN 21 OF 171.10	12. HCT/Ps REGULATED AS MEDICAL DEVICES	13. HCT/Ps REGULATED AS DRUGS OR BIOLOGICAL DRUGS	14. PROPRIETARY NAME(S)																			
3. OTHER FDA REGISTRATIONS a. BLOOD FDA 2830 NO. _____ b. DEVICES FDA 2891 NO. _____ c. DRUG FDA 2656 NO. _____	10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps <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	
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4. PHYSICAL LOCATION (Include legal name, number and street, city, state, country, and post office code) Eversight New Jersey 77 Brant Avenue, Suite 100 Clark, New Jersey 07066 a. PHONE 732-382-3060 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 type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous f. Fascia g. Heart Valve h. Ligament i. Oocyte <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input 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 type="checkbox"/> SIP <input type="checkbox"/> Directed <input 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																							
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) Eversight Attn: Kevin W. Ross 4889 Venture Drive Ann Arbor, Michigan 48108 a. PHONE 734-780-2100 EXT _____ b. PHONE _____	s. t. u. v.																							
7. ENTER CORRECTIONS TO ITEM 6																								
8. U.S. AGENT a. E-MAIL _____																								
9. REPORTING OFFICIAL'S SIGNATURE a. TYPED NAME Kevin W. Ross b. E-MAIL kwross@eversightvision.org c. TITLE President/CEO d. DATE 28-NOV-2016																								