

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: 3009826876	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:26-NOV-2015 DISTRICT: New Orleans PRINTED BY FDA:03-DEC-2015
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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)
3. OTHER FDA REGISTRATIONS	10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps												
	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) DCI Donor Services dba Tennessee Donor Services (Nashville) 1900 Patterson Street Nashville, Tennessee 37203 a. PHONE 615-564-3600 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			
	b. Cartilage	X	X							X			
	c. Cornea	X	X		X		X	X	X	X			
5. ENTER CORRECTIONS TO ITEM 4	d. Dura Mater												
	e. Embryo <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous												
	f. Fascia	X	X							X			
6. MAILING ADDRESS OF REPORTING OFFICIAL (Include institution name if applicable, number and street, city, state, country, and post office code) DCI Donor Services dba Tennessee Donor Services (Nashville) Attn: Chad F. Beemer 1600 Hayes Street Suite 300 Nashville, Tennessee 37203 a. PHONE 615-564-3676 EXT _____	g. Heart Valve	X	X							X			
	h. Ligament	X	X							X			
	i. Oocyte <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous												
7. ENTER CORRECTIONS TO ITEM 6 b. PHONE _____	j. Pericardium	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	X	X	X	X	X			
8. U.S. AGENT a. E-MAIL _____	m. Semen <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous												
	n. Skin	X	X							X			
	o. Somatic Cell Therapy Products <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic												
9. REPORTING OFFICIAL'S SIGNATURE a. TYPED NAME Chad F. Beemer b. E-MAIL chad.beemer@dcids.org c. TITLE Director of Quality and Compliance d. DATE 25-NOV-2015	p. Tendon	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			
	s.												
	t.												
	u.												
	v.												