

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

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.

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)

Community Blood Center of the Ozarks
220 West Platinview
Springfield, MO 65810

4.1 PHONE 417-227-5000

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.)

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

Community Blood Center of the Ozarks
ATTN: Don F. Thomson
220 West Platinview
Springfield, MO 65810

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

8.1 TYPED NAME Don F. Thomson
8.2 E-MAIL ADDRESS thomasd@cbco.org
8.3 PHONE 417-227-5301

8.4 DATE

1. REGISTRATION NUMBER
FBI: 3007349184
CFR:
2. U.S. LICENSE NUMBER
1276

3. REASON FOR SUBMISSION
1. ANNUAL REGISTRATION
2. INITIAL REGISTRATION
3. CHANGE IN INFORMATION



This form is authorized by Sections 510(b), (i) and 704 of the Federal Food, Drug, and Cosmetic Act (Title 21, United States Code 360(b), (i) 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: Kansas City
VALIDATED BY FDA: 21-JAN-2010
PRINTED BY FDA: 21-JAN-2010

9. TYPE OF OWNERSHIP
1. SINGLE PROPRIETORSHIP
2. PARTNERSHIP
3. CORPORATION profit non-profit
4. COOPERATIVE ASSOCIATION
5. FEDERAL (non-military)
6. U.S. MILITARY
7. STATE
8. COUNTY/MUNICIPAL/HOSPITAL AUTHORITY
9. OTHER (Specify):

10. TYPE ESTABLISHMENT (Check all boxes that describe routine or autologous operations.)
1. COMMUNITY (NON-HOSPITAL) BLOOD BANK
2. HOSPITAL BLOOD BANK
3. PLASMAPHERESIS CENTER
4. PRODUCT TESTING LABORATORY
a. INDEPENDENT
b. ASSOCIATED w/ COMMUNITY or HOSPITAL BLOOD BANK
5. HOSPITAL TRANSFUSION SERVICE
a. APPROVED FOR MEDICARE REIMBURSEMENT
b. NOT APPROVED FOR MEDICARE REIMBURSEMENT
6. COMPONENT PREPARATION FACILITY
7. COLLECTION FACILITY
8. DISTRIBUTION CENTER
9. BROKERWAREHOUSE
10. 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 TESTED (7)	TEST (8)	STORE AND DISTRIBUTE TO OTHERS (9)
WHOLE BLOOD	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
RED BLOOD CELLS (RBC)						<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
RBC FROZEN							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
RBC DEGLYCEROLIZED							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
RBC RELEVANATED												
RBC RELEVANATED FROZEN												
RBC RELEVANATED DEGLYCEROLIZED												
CRYOPRECIPITATED AHF						<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
PLATELETS						<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
LEUKOCYTES/GRANULOCYTES												
PLASMA							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
PLASMA CRYOPRECIPITATE REDUCED							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
FRESH FROZEN PLASMA							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
LIQUID PLASMA												
THERAPEUTIC EXCHANGE PLASMA												
SOURCE LEUKOCYTES												
SOURCE PLASMA												
RECOVERED PLASMA							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
BLOOD PRODUCTS FOR DIAGNOSTIC USE				<input checked="" type="checkbox"/>								
BLOOD BANK REAGENTS												
OTHER Platelets Washed							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
OTHER Red Blood Cells Washed							<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>