

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: 1000025033	<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:13-DEC-2016 DISTRICT: Florida PRINTED BY FDA:28-DEC-2016
---	--	--	--

PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION																								
<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">Establishment Functions</th> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">11. HCT/Ps DESCRIBED IN 21 OF 171.10</th> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">12. HCT/Ps REGULATED AS MEDICAL DEVICES</th> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">13. HCT/Ps REGULATED AS DRUGS OR BIOLOGICAL DRUGS</th> <th rowspan="2" style="width:15%;">14. PROPRIETARY NAME(S)</th> </tr> <tr> <th>Recover</th> <th>Screen</th> <th>Test</th> <th>Package</th> <th>Process</th> <th>Store</th> <th>Label</th> <th>Distribute</th> </tr> </thead> </table>	Types of HCT / Ps	Establishment Functions									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)	Recover	Screen	Test	Package	Process	Store	Label	Distribute		
Types of HCT / Ps	Establishment Functions									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)								
	Recover	Screen	Test	Package	Process	Store	Label	Distribute																	
<b>4. PHYSICAL LOCATION</b> (Include legal name, number and street, city, state, country, and post office code) Florida Lions Eye Bank  900 NW 17th Street #348 Miami, Florida 33136  a. PHONE 305-324-4340 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																								
<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) Florida Lions Eye Bank Attn: Elizabeth Fout-Caraza PO Box 016880 Miami, Florida 33101  a. PHONE 305-482-4323 EXT _____																									
<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 Elizabeth Fout-Caraza b. E-MAIL Efcaraza@med.miami.edu c. TITLE Executive Director d. DATE 12-DEC-2016	s. t. u. v.																								