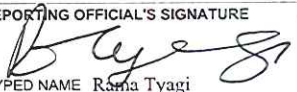


DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE FOOD AND DRUG ADMINISTRATION ESTABLISHMENT REGISTRATION AND LISTING FOR HUMAN CELLS, TISSUES, AND CELLULAR AND TISSUE-BASED PRODUCTS (HCT/PS) (See reverse side for instructions)		1. REGISTRATION NUMBER (Field Establishment Identifier) FEI: 1000519667	2. REASON FOR SUBMISSION a. <input type="checkbox"/> INITIAL REGISTRATION / LISTING b. <input type="checkbox"/> ANNUAL REGISTRATION / LISTING c. <input checked="" type="checkbox"/> CHANGE IN INFORMATION d. <input type="checkbox"/> INACTIVE	VALIDATION--FOR FDA USE ONLY VALIDATED BY FDA: 11-FEB-2011 DISTRICT: Los Angeles PRINTED BY FDA: 11-FEB-2011								
PART I - ESTABLISHMENT INFORMATION		PART II - PRODUCT INFORMATION						11. HCT/PS DESCRIBED IN 21 CFR 127.110 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										
4. PHYSICAL LOCATION (Include legal name, number and street, city, state, country, and post office code) California Cryobank, Inc. 1019 Gayley Ave. Los Angeles, California 90024 a. PHONE 310-443-5244 EXT 1165 b. <input type="checkbox"/> SATELLITE RECOVERY ESTABLISHMENT (MANUFACTURING ESTABLISHMENT FEI NO. _____) c. <input type="checkbox"/> TESTING FOR MICRO-ORGANISMS ONLY		Types of HCT / Ps	Establishment Functions									
5. ENTER CORRECTIONS TO ITEM 4		Recover	Screen	Test	Package	Process	Store	Label	Distribute			
6. MAILING ADDRESS OF REPORTING OFFICIAL (Include institution name if applicable, number and street, city, state, country, and post office code) California Cryobank, Inc. Attn: Rama Tyagi 11915 La Grange Avenue Los Angeles, California 90025-5213 a. PHONE 310-443-5244 EXT 1172		a. Bone										
7. ENTER CORRECTIONS TO ITEM 6		b. Cartilage										
b. PHONE _____		c. Cornea										
8. U.S. AGENT		d. Dura Mater										
a. E-MAIL _____		e. Embryo <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous										
9. REPORTING OFFICIAL'S SIGNATURE  a. TYPED NAME Rama Tyagi b. E-MAIL rtyagi@cryobank.com c. TITLE Director, Quality/Regulatory Affairs d. DATE 10-FEB-2011		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 checked="" type="checkbox"/> Anonymous	X	X		X	X	X	X	X		
		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										
		s.										
		t.										
		u.										
		v.										