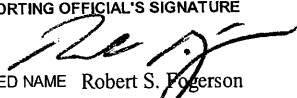


DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE FOOD AND DRUG ADMINISTRATION ESTABLISHMENT REGISTRATION AND LISTING FOR HUMAN CELLS, TISSUES, AND CELLULAR AND TISSUE-BASED PRODUCTS (HCT/Ps) <i>(See reverse side for instructions)</i>	1. REGISTRATION NUMBER (Field Establishment Identifier) FEI: 0002183472	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:18-NOV-2009 DISTRICT: Minneapolis PRINTED BY FDA:02-DEC-2009
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION			14. PROPRIETARY NAME(S)										
3. OTHER FDA REGISTRATIONS a. BLOOD FDA 2830 NO. FEI: 0002183472 b. DEVICES FDA 2891 NO. FEI: 0002183472 c. DRUG FDA 2656 NO. _____	10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps													
	<i>Types of HCT / Ps</i>	<i>Establishment Functions</i>												
	Recover	Screen	Test	Package	Process	Store	Label	Distribute	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			
4. PHYSICAL LOCATION <i>(Include legal name, number and street, city, state, country, and post office code)</i> Laboratory Corporation of America ViroMed Laboratories 6101 Blue Circle Dr. Minnetonka, Minnesota 55343 a. PHONE 952-563-3300 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				
	b. Cartilage			X						X				
	c. Cornea			X						X				
	d. Dura Mater													
	e. Embryo <input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous			X							X			
	f. Fascia			X							X			
	5. ENTER CORRECTIONS TO ITEM 4	g. Heart Valve			X						X			
		h. Ligament			X						X			
		i. Oocyte <input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous			X							X		
	6. MAILING ADDRESS OF REPORTING OFFICIAL <i>(Include institution name if applicable, number and street, city, state, country, and post office code)</i> ViroMed Laboratories Attn: Robert S. Fogerson 6101 Blue Circle Dr. Minnetonka, Minnesota 55343 a. PHONE 952-563-4024 EXT _____	j. Pericardium			X						X			
		k. Peripheral Blood Stem <input checked="" type="checkbox"/> Autologous <input checked="" type="checkbox"/> Family Related <input checked="" type="checkbox"/> Allogeneic			X							X		
		l. Sclera			X							X		
		m. Semen <input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous			X							X		
		7. ENTER CORRECTIONS TO ITEM 6	n. Skin			X						X		
			o. Somatic Cell Therapy Products <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic											
8. U.S. AGENT	p. Tendon			X						X				
	q. Umbilical Cord Blood Stem Cells <input checked="" type="checkbox"/> Autologous <input checked="" type="checkbox"/> Family Related <input checked="" type="checkbox"/> Allogeneic			X							X			
	r. Vascular Graft			X						X				
9. REPORTING OFFICIAL'S SIGNATURE  a. TYPED NAME Robert S. Fogerson b. E-MAIL bfogerson@labcorp.com c. TITLE General Manager d. DATE 16-NOV-2009.	s.													
	t.													
	u.													
	v.													