

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: 0001472204

2. REASON FOR SUBMISSION
 a. INITIAL REGISTRATION / LISTING
 b. ANNUAL REGISTRATION / LISTING
 c. CHANGE IN INFORMATION
 d. INACTIVE

VALIDATION-FOR FDA USE ONLY
 VALIDATED BY FDA:14-DEC-2011
 DISTRICT: Chicago
 PRINTED BY FDA:15-DEC-2011

PART I - ESTABLISHMENT INFORMATION
3. OTHER FDA REGISTRATIONS
 a. BLOOD FDA 2830 NO. FEI 2008744240
 b. DEVICES FDA 2891 NO. _____
 c. DRUG FDA 2856 NO. _____

PART II - PRODUCT INFORMATION
10. ESTABLISHMENT FUNCTIONS AND TYPES OF HCT / Ps

Types of HCT / Ps	Establishment Functions									11. HCT/PS DERIVED IN 10 OR 12/13	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					

4. PHYSICAL LOCATION *(Include legal name, number and street, city, state, country, and post office code)*
 LifeSource
 Testing Lab
 5505 Pearl St
 Rosemont, Illinois 60018
 a. PHONE 847-260-2683 EXT _____
 b. SATELLITE RECOVERY ESTABLISHMENT
 (MANUFACTURING ESTABLISHMENT FEI NO. _____)
 c. TESTING FOR MICRO-ORGANISMS ONLY

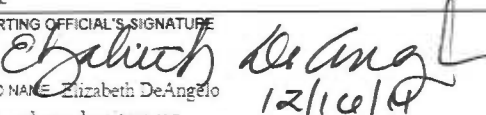
a. Bone			X							X	X	X	
b. Cartilage			X							X	X	X	
c. Cornea			X							X	X	X	
d. Dura Mater			X							X	X	X	
e. Embryo	<input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous		X							X	X	X	
f. Fascia			X							X	X	X	
g. Heart Valve			X							X	X	X	
h. Ligament			X							X	X	X	
i. Oocyte	<input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous		X							X	X	X	
j. Pericardium			X							X	X	X	
k. Peripheral Blood Stem Cells	<input checked="" type="checkbox"/> Autologous <input checked="" type="checkbox"/> Family Related <input checked="" type="checkbox"/> Allogeneic		X							X	X	X	
l. Sclera			X							X	X	X	
m. Semen	<input checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" type="checkbox"/> Anonymous		X							X	X	X	
n. Skin			X							X	X	X	
o. Somatic Cell Therapy Products	<input checked="" type="checkbox"/> Autologous <input checked="" type="checkbox"/> Family Related <input checked="" type="checkbox"/> Allogeneic		X							X	X	X	
p. Tendon			X							X	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	X	X	
r. Vascular Graft			X							X	X	X	
s. Amniotic Membrane			X							X	X	X	
t. Pancreatic Islet Cells - autologous			X							X	X	X	
u. Placenta			X							X	X	X	
v. Therapeutic Cells			X							X	X	X	
w. Umbilical Cord			X							X	X	X	

5. ENTER CORRECTIONS TO ITEM 4

6. MAILING ADDRESS OF REPORTING OFFICIAL *(Include institution name if applicable, number and street, city, state, country, and post office code)*
 Institute for Transfusion Medicine
 Attn: Elizabeth DeAngelo
 Five Parkway Center
 875 Greentree Road
 Pittsburgh, Pennsylvania 15220
 a. PHONE 412-209-7042 EXT _____

7. ENTER CORRECTIONS TO ITEM 6 a. PHONE _____ b. PHONE _____

8. U.S. AGENT
 a. E-MAIL _____

9. REPORTING OFFICIAL'S SIGNATURE

 a. TYPED NAME Elizabeth DeAngelo
 b. E-MAIL edeangelo@rxnm.org
 c. TITLE Quality Assurance Manager
 d. DATE 13-DEC-2011