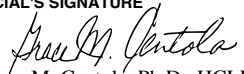


DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE FOOD AND DRUG ADMINISTRATION ESTABLISHMENT REGISTRATION AND LISTING FOR HUMAN CELLS, TISSUES, AND CELLULAR AND TISSUE-BASED PRODUCTS (HCT/Ps) (See reverse side for instructions)	1. REGISTRATION NUMBER (FDA Establishment Identifier) FEI: 3005374514	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:17-NOV-2017 DISTRICT: New England PRINTED BY FDA:27-JAN-2018
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION	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	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 <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" style="text-align: center;">Establishment Functions</th> </tr> <tr> <th style="width:5%;">Recover</th> <th style="width:5%;">Screen</th> <th style="width:5%;">Test</th> <th style="width:5%;">Package</th> <th style="width:5%;">Process</th> <th style="width:5%;">Store</th> <th style="width:5%;">Label</th> <th style="width:5%;">Distribute</th> <th style="width:5%;"></th> </tr> </thead> </table>					Types of HCT / Ps	Establishment Functions									Recover	Screen	Test	Package	Process	Store	Label	Distribute	
Types of HCT / Ps	Establishment Functions																							
	Recover	Screen	Test	Package	Process	Store	Label	Distribute																
4. PHYSICAL LOCATION (Include legal name, number and street, city, state, country, and post office code) New England Cryogenic Center, Inc. 188 Needham Street Suite 230 Newton, Massachusetts 02464 a. PHONE 617-631-8380 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 checked="" 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 checked="" type="checkbox"/> SIP <input checked="" type="checkbox"/> Directed <input checked="" 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																							
5. ENTER CORRECTIONS TO ITEM 4	s. Testicular Tissue t. u. v.																							
6. MAILING ADDRESS OF REPORTING OFFICIAL (Include institution name if applicable, number and street, city, state, country, and post office code) New England Cryogenic Center Attn: Grace M. Centola, Ph.D., HCLD (ABB) 188 Needham Street Suite 230 Newton, Massachusetts 02464 a. PHONE 617-631-8380 EXT _____																								
7. ENTER CORRECTIONS TO ITEM 6																								
8. U.S. AGENT a. E-MAIL _____																								
9. REPORTING OFFICIAL'S SIGNATURE  a. TYPED NAME Grace M. Centola, Ph.D., HCLD (ABB) b. E-MAIL gcentola@necryogenic.com c. TITLE Tissue Bank Director d. DATE 16-NOV-2017																								