## **BLOOD BANK PERSONNEL REPORT**

Name of Blood Bank or Collection Center				Californi	a Biologics ID No.	Teleph	Telephone No.					
Facility Address (Number, Street)						State	Zip Co	ode				
Contact Person(s) Email – Please provide two valid email addresses				Contact	Person's Fax No.	Contac	Contact Name					
Facility Hours												
Monday	Tuesday	Wednesday	Thur	sday	Friday	Saturd	ay	Sunday				

Clinical Laboratory License or Registration No.	Accredited?	Accrediting Agency	Last On-site Visit Date
	□Yes □No		
CLIA No.	Last On-site Visit Date	FDA License or Registration No.	Last On-site Visit Date

1. List attending physician(s) and all personnel performing or directly supervising the performance of any clinical laboratory tests. Include personnel performing waived, moderate, and high complexity tests. Please include license numbers when selecting non-waived testing personnel.

			Hours			D	ays	3			CA License	Test Complexity Performed
First Name	МІ	From	То	М	т	W	Т	F	s	s	Type & No.	Performed Use W,M,H
	First Name	First Name MI										Hours Days License Type &

2. List all personnel performing capillary puncture, venipuncture, or apheresis (C, V, A).

			Ho	Hours Days				CA License Type & No.	Procedures Performed (C, V, A)				
Last Name	First Name	MI	From	То	М	т	w	Th	F	s	s	Type & No.	Performed (C, V, A)
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Signature of Medical Director or person in ch		
Medical Director Printed Name	Medical Director Signature	Date