BLOOD BANK PERSONNEL REPORT

Name of Blood Bank or Collection Center	California Biologics ID number	Telephone ( )	
Facility Address(number, street)	City	State	Zip Code
Contact Person(s) Email Address – **Please provide two valid addresses**	Contact Person Fax Number ( )	Contact Name	
Facility Hours: Monday Tuesday Wednesday Thursday Friday Saturday Sunday			

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.**

Last Name	First Name	MI	Hours		Days						CA License Type and Number	Test Complexity Performed Use W,M.H
			From	To	M	T	W	T	F	S		

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

					Days							
Last Name	**First Name**	**MI**	**Hours**		**M**	**T**	**W**	**T**	**F**	**S**	**CA License Type and #**	**Procedures Performed C, V, A**
			From	**To**								

Signature of Medical Director or person in charge of biologics production

_____ _____

Medical Director Date

Medical Director – Please print name _____