

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION
BLOOD ESTABLISHMENT REGISTRATION AND PRODUCT LISTING**

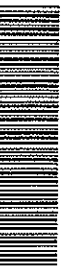
1. REGISTRATION NUMBER
FEI: 3007238812
CFN:

2. U.S. LICENSE NUMBER

3. REASON FOR SUBMISSION
1. ANNUAL REGISTRATION
2. INITIAL REGISTRATION
3. CHANGE IN INFORMATION

FOR FDA USE ONLY

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This form is authorized by Sections 510(b), (f) and 704 of the Federal Food, Drug, and Cosmetic Act (Title 21, United States Code 360(b), (f) and 374). Failure to report this information is a violation of Section 301(f) and (p) of the Act (Title 21, United States Code 331(f) and (p)) and can result in a fine of up to \$1,000 or imprisonment up to one year or both, pursuant to Section 303(a) of the Act (Title 21, United States Code 333(a)).

DISTRICT OFFICE: Atlanta
VALIDATED BY FDA: 07-DEC-2012
PRINTED BY FDA: 09-JAN-2013

PLEASE READ INSTRUCTIONS CAREFULLY. Be sure to indicate any changes in your legal name or actual location in item 4, and any changes in your mailing address in item 6. Print all entries and make all corrections in red ink, if possible. Enter your phone number in item 8.3 and the phone number of your actual location in item 4.1. Sign the form and return to FDA. After validation, you will receive your Official Registration for the ensuing year.

ENTER ALL CHANGES IN RED INK AND CIRCLE.

4. LEGAL NAME AND LOCATION (include legal name, number and street, city, state, country, and post office code)

Atlanta Blood Services
220 Cobb Parkway
Suite 100
Marietta, GA 30062

4.1 PHONE 404-459-8744

5. OTHER NAMES USED AT THIS LOCATION (include trade name, doing-business-as, previous names, and other firms co-located. If applicable, include registration number.)

6. MAILING ADDRESS OF REPORTING OFFICIAL (include institution name if applicable, number and street, city, state, country, and post office code)

Atlanta Blood Services
ATTN: Carrie S. Cox
5670 Peachtree Dunwoody
Suite 1075
Atlanta, GA 30342

7. U.S. AGENT (include name, institution name if applicable, number and street, city, state, and zip code)

7.1 E-MAIL ADDRESS
7.2 PHONE

8. REPORTING OFFICIAL'S SIGNATURE

8.1 TYPED NAME Carrie S. Cox
8.2 E-MAIL ADDRESS ccox@dmnga.com
8.3 PHONE 404-459-8744
8.4 DATE

9. TYPE OF OWNERSHIP

1. SINGLE PROPRIETORSHIP
2. PARTNERSHIP
3. CORPORATION non-profit profit
4. COOPERATIVE ASSOCIATION
5. FEDERAL (non-military)
6. U.S. MILITARY
7. STATE
8. COUNTY/MUNICIPAL/HOSPITAL AUTHORITY
9. OTHER (Specify):

10. TYPE ESTABLISHMENT (Check all boxes that describe routine or autologous operations.)

1. COMMUNITY (NON-HOSPITAL) BLOOD BANK
2. HOSPITAL BLOOD BANK
3. PLASMAPHERESIS CENTER
4. PRODUCT TESTING LABORATORY
5. INDEPENDENT
6. ASSOCIATED w/ COMMUNITY or HOSPITAL BLOOD BANK
7. HOSPITAL TRANSFUSION SERVICE
8. APPROVED FOR MEDICARE REIMBURSEMENT
9. NOT APPROVED FOR MEDICARE REIMBURSEMENT
10. COMPONENT PREPARATION FACILITY
11. COLLECTION FACILITY
12. DISTRIBUTION CENTER
13. BROKER/WAREHOUSE
14. OTHER (Specify):

U.S. LICENSE NUMBER OF PARENT FIRM

11. PRODUCTS	ALLOGENIC	AUTOLOGOUS	DIRECTED	COLLECT	MANUAL APHERESIS	AUTOMATED APHERESIS	PREPARE	LEUKOCYTES REDUCED	IRRADIATED	DOOR REFINED	TEST	STORE and DISTRIBUTE to OTHERS
				(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
WHOLE BLOOD	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	X								X
RED BLOOD CELLS (RBC)						X		X				X
RBC FROZEN												
RBC DEGLYCEROLIZED												
RBC RELEVANATED												
RBC RELEVANATED FROZEN												
RBC RELEVANATED DEGLYCEROLIZED												
CRYOPRECIPITATED AHF												
PLATELETS						X						X
LEUKOCYTES/GRANULOCYTES								X				X
PLASMA												
PLASMA CRYOPRECIPITATE REDUCED												
FRESH FROZEN PLASMA							X					
LIQUID PLASMA								X				X
THERAPEUTIC EXCHANGE PLASMA												
SOURCE LEUKOCYTES												
SOURCE PLASMA												
RECOVERED PLASMA												
BLOOD PRODUCTS FOR DIAGNOSTIC USE												
BLOOD BANK REAGENTS												
OTHER												