

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) <i>(See reverse side for instructions)</i>	1. REGISTRATION NUMBER (Field Establishment Identifier) FEI: 3001451642	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-2009 DISTRICT: Chicago PRINTED BY FDA:17-NOV-2009
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PART I - ESTABLISHMENT INFORMATION	PART II - PRODUCT INFORMATION																						
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> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">11. HCT/Ps DESCRIBED IN 21 CFR 1271.10</th> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">12. HCT/Ps REGULATED AS MEDICAL DEVICES</th> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">13. HCT/Ps REGULATED AS DRUGS OR BIOLOGICAL DRUGS</th> <th rowspan="2" style="width:15%;">14. PROPRIETARY NAME(S)</th> </tr> <tr> <th>Recover</th> <th>Screen</th> <th>Test</th> <th>Package</th> <th>Process</th> <th>Store</th> <th>Label</th> <th>Distribute</th> </tr> </thead> </table>	Types of HCT / Ps	Establishment Functions									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)	Recover	Screen	Test	Package	Process	Store	Label	Distribute
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4. PHYSICAL LOCATION <i>(Include legal name, number and street, city, state, country, and post office code)</i> Illinois Eye-Bank 547 West Jackson Blvd., Suite 600 Chicago, Illinois 60661 a. PHONE 312-706-6750 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 <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen <input checked="" type="checkbox"/> Test <input checked="" type="checkbox"/> Package <input checked="" type="checkbox"/> Process <input checked="" type="checkbox"/> Store <input checked="" type="checkbox"/> Label <input checked="" type="checkbox"/> Distribute <input checked="" type="checkbox"/> 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 type="checkbox"/> Anonymous j. Pericardium k. Peripheral Blood Stem Cells <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic l. Sclera <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen <input checked="" type="checkbox"/> Test <input checked="" type="checkbox"/> Package <input checked="" type="checkbox"/> Process <input checked="" type="checkbox"/> Store <input checked="" type="checkbox"/> Label <input checked="" type="checkbox"/> Distribute <input checked="" type="checkbox"/> m. Semen <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input 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 Stem Cells <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic r. Vascular Graft s. t. u. v.																						
5. ENTER CORRECTIONS TO ITEM 4																							
6. MAILING ADDRESS OF REPORTING OFFICIAL <i>(Include institution name if applicable, number and street, city, state, country, and post office code)</i> Midwest Eye-Banks Attn: Kevin W. Ross 4889 Venture Dr. Ann Arbor, Michigan 48108 a. PHONE 734-780-2100 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 Kevin W. Ross b. E-MAIL kwross@midwesteyebanks.org c. TITLE President / CEO d. DATE 16-NOV-2009																							

THE EYE BANK ASSOCIATION OF AMERICA

CERTIFIES THAT

***ILLINOIS EYE BANK—WATSON
GAILEY, MIDWEST EYE BANKS***

Bloomington, IL

*has met the requirements for
EYE BANK ACCREDITATION
as prescribed by the Eye Bank Association of America
in accordance with its Medical Standards,
confirmed by the signatures herewith inscribed.*



Chairman

Spring 2008

Date Granted



President

Spring 2011

Date Expired

