

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: 3004104395	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:16-DEC-2009 DISTRICT: San Francisco PRINTED BY FDA:18-DEC-2009
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4. PHYSICAL LOCATION <i>(Include legal name, number and street, city, state, country, and post office code)</i> OneLegacy - Bakersfield 1100 Mohawk Street, Suite 150 Bakersfield, California 93309 a. PHONE 661-635-0279 EXT _____ b. <input checked="" type="checkbox"/> SATELLITE RECOVERY ESTABLISHMENT (MANUFACTURING ESTABLISHMENT FEI NO. 3005879987) c. <input type="checkbox"/> TESTING FOR MICRO-ORGANISMS ONLY	a. Bone <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen b. Cartilage <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen c. Cornea <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen d. Dura Mater e. Embryo <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous f. Fascia <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen g. Heart Valve <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen h. Ligament <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen i. Oocyte <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous j. Pericardium <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen k. Peripheral Blood Stem <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 m. Semen <input type="checkbox"/> SIP <input type="checkbox"/> Directed <input type="checkbox"/> Anonymous n. Skin <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen o. Somatic Cell Therapy Products <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic p. Tendon <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen q. Umbilical Cord Blood Stem Cells <input type="checkbox"/> Autologous <input type="checkbox"/> Family Related <input type="checkbox"/> Allogeneic r. Vascular Graft <input checked="" type="checkbox"/> Recover <input checked="" type="checkbox"/> Screen																									
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5. ENTER CORRECTIONS TO ITEM 4					
6. MAILING ADDRESS OF REPORTING OFFICIAL *(Include institution name if applicable, number and street, city, state, country, and post office code)* OneLegacy Attn: Alan J. Cochran, MHA, CTBS 221 South Figueroa Street, Suite 500 Los Angeles, California 90012 a. PHONE 213-229-5662 EXT _____ b. PHONE _____					
7. ENTER CORRECTIONS TO ITEM 6					
8. U.S. AGENT a. E-MAIL _____					
9. REPORTING OFFICIAL'S SIGNATURE a. TYPED NAME Alan J. Cochran, MHA, CTBS b. E-MAIL acochran@onelegacy.org c. TITLE VP, Quality Systems d. DATE 15-DEC-2009					