



Facility Name: _____

Facility Address: _____

City, State Zip Code: _____

This agreement is to document facilities which Facility Name: _____ contracts with in the processing, production, handling, testing, transport, or storage of HCT/Ps.

Establishment Name: Fairfax Cryobank and Cryogenic Laboratories, Inc.

Address: 3015 Williams Drive, Suite 110

Address: Fairfax, VA 22031

Phone: 703-698-3976

Fax: 703-698-3933

This facility: Is not required to hold a CLIA license

Holds a current CLIA license (semen analysis only)

CLIA Number: 49D1102767, 24D0399536

Issuing Agency: Virginia Department of Health

Director: Michelle Ottey, Ph.D. (HCLD)

This facility is not registered with the FDA as a HCT/P establishment

This facility is currently registered with the FDA as a HCT/P establishment

Registration Number: 3004731690, 3000243835

FDA establishment registration functions include:

Recover Screen Test * Package Store Label Distribute

I agree Fairfax Cryobank and Cryogenic Laboratories, Inc. (hereafter referred to as "Cryobank") will maintain FDA registration for HCT/Ps as required. In addition, Cryobank will remain compliant with all regulations governing the manufacture of HCT/Ps.

Facility Name: _____ agrees to notify Cryobank within 48 hours of any finding from an audit or inspection which effects HCT/Ps distributed by Cryobank.

* While Cryobank does not directly perform "testing" we do contract with a FDA registered, CLIA licensed testing facility using only FDA approved screening tests for donor testing. Tests are conducted and interpreted as per manufacture recommendations.

I agree to notify Facility Name: _____ within 5 business days of any change in our status.

Responsible Person Printed Name: _____

Responsible Person Signature: _____ **Date:** _____

Form Number: GQ-005 F.002	Contract Establishment Agreement	Revision: A	Effective: 01/01/14
------------------------------	----------------------------------	-------------	------------------------