AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, MS#32
Tallahassee, Florida 32308
(850) 487 - 3109

Application for Certification
Organ Procurement Organization,
Tissue Bank or Eye Bank

Part I **Type and Directors (Please print or type)**

A. Check One

Organ Procurement Organization ☐

Tissue Bank ☐

Eye Bank ☐

B. Name of Agency (Legal)

____

Name (Doing Business As)

____

Address

____

____

City ____________ County ______________ State ________ Zip ________

Phone ________________ Fax ________________

C. Agency Director

____

Medical Director ____

(Please attach resume or curriculum vitae.)

D. Ownership (Select One)

Individual ☐ Government ☐ Other ☐

Partnership ☐ Corporation ☐

(If the applicant is a partnership, provide a copy of the partnership agreement. If a corporation, include a copy of the articles of incorporation.)

E. Nature of Site (Select one)

Hospital ☐ Independent ☐

Blood Bank ☐ Other Office ☐

Part II Board of Directors and/or Advisory Board

A. Agency Board of Directors

Name____

Area of Expertise
____

Name____

Area of Expertise
____

Name____

Area of Expertise
____

Name____

Area of Expertise
____

Name____

Area of Expertise
____

(Attach additional pages as necessary.)

B. Medical Advisory Board

Name____

Area of Expertise
____

Name____

Area of Expertise
____

Name____

Area of Expertise
____

Name____

Area of Expertise
____

Name____
_

Area of Expertise
____

(Attach additional pages as necessary.)

Part III Site Location and Equipment

A. Description of Site

Please provide a drawing or a blueprint of the agency's main site which includes the square footage.

Is there more than one site? Yes ☐ No ☐

Is the space contiguous? Yes ☐ No ☐

If more than one site, list sites other than the main site and give the square footage of each.

____

____

(Attach additional pages as necessary.)

2. Is the agency sharing the site(s) with another health provider? Yes ☐ No ☐ If yes, explain.

____

____

(Attach additional pages as necessary.)

B. Equipment

List and briefly describe equipment used.

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____

____

(Attach additional pages as necessary.)

Part IV Donor Selection and Testing

A. Attach copies of donor selection criteria, health history form, consent form, social history form and applicable protocols.

B. List all laboratory tests performed on donors or donated organs and/or tissues and indicate site of testing. If tests are performed by the applicant, indicate "on-site."

Analyte(s)	Reference Lab(s) Name and Address
______________________	
	Name ______________________
	Street ______________________

____ City ______________________ State _________
Zip________

Analyte(s) Reference Lab(s) Name and Address

____

____

Name ____

Street ____

______________________________________ City ____________________ State _________ Zip________

Name ____

Street ____

______________________________________ City ____________________ State _________ Zip________

Name ____

Street ____

______________________________________ City ____________________ State _________ Zip________

(Attach additional pages as necessary.)

C. For any testing laboratory outside of Florida, please supply (1) state licensure; (2) Medicare certificate; and/or (3) interstate certification, as applicable.

Part V Signatures of Affirmation

I understand that in order to obtain Florida certification as an OPO, tissue bank or eye bank, I must comply with the provisions as set forth in Chapter 873, Florida Statutes, Sale of Anatomical Matter. In addition, I hereby affirm under penalty of perjury that information provided on this form is true to the best of my knowledge and belief. By applying for and if granted certification, the OPO, tissue bank or eye bank and each employee or agent grants the AHCA or its designee permission to enter upon any premise controlled, operated, or owned by the OPO, tissue bank or eye bank and to obtain records to inspect, to audit, and to interview any employees or agents of the agency, 9 a.m. to 5 p.m. local time Monday through Friday. The agency agrees to cooperate with the AHCA or its designee in permitting and facilitating the above activities.

______________________	______________________	______________
Director's Name (Print)	Director's Signature	Date
Medical Director's Name (Print)	Medical Director's Signature	Date
Officer of Owner's Name (Print)	Officer or Owner's Signature	Date