NEW YORK STATE DEPARTMENT OF HEALTH

Tissue Resources Program

Application for ARTSP Registration

PART I - Facility and Contact Information

Name of Facility			
Doing Business As (Optional)			
New York State Tissue Bank Facility Identification Number			
Street Address			
Street Address			
City	State	Zip	County
Telephone		Fax	
Contact E-Mail Address(es)			

Mailing address (if different from above):

PART II – Director

A. For a Director who already has an HCS account:

Director's Name	
Director's HCS Account Number	

B. For a Director who does not have an HCS account:

Director's First Name		Middle Name	
Last Name		Month and Day of Birth	
Title			
Work Address			
City	State	Zip	Office Telephone
Fax	E-Mail Address		

For Tissue Resources Program use only

○ New Application

◉ Amended Application

Facility ID _____

Date Received _____

PART III – Annual Gestational Surrogacy Procedures

A. Provide the estimated annual number of gestational surrogacy procedures:

IVF	Embryo Transfer
Gamete Intrafallopian Transfer	Other

PART IV – Signature

Providing false or misleading information in this statement may lead to prosecution under applicable federal or state laws and may result in denial of the New York State Department of Health Tissue Resources Program Application for Licensure.

I hereby affirm under penalty of perjury that the information provided on this form and all attachments is true to the best of my knowledge and belief.

Name of Authorized Representative | **Title**

Phone Number | **E-mail Address**

Signature | **Date**

The completed application, additional required forms, and supporting documentation must be submitted to the New York State Department of Health Tissue Resources Program.

By e-mail as a pdf (preferred) to: tissue@health.ny.gov

By mail to: Tissue Resources Program
Wadsworth Center
New York State Department of Health
Empire State Plaza
Albany, NY 12237