NEW YORK STATE DEPARTMENT OF HEALTH
Tissue Resources Program
Wadsworth Center, Empire State Plaza
Albany, NY 12237

Application for ARTSP Registration

PART I – FACILITY AND CONTACT INFORMATION

Name of Facility			
Doing Business As (optional)			
New York State Tissue Bank Facility ID #			
Facility Address			
City	State	ZIP	County
Fax	Telephone		
Contact E-Mail Address(es)			

Mailing address (if different from above):

PART II – DIRECTOR

Director's First Name	Director's Middle Name		
Director's Last Name	Date of Birth		
Title			
Work Address			
City	State	ZIP	Fax
Office Telephone	E-Mail Address		
Does the Director have an existing HCS account? ☐ Yes ☐ No If "Yes", Director's HCS ID:			

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