NEW YORK STATE DEPARTMENT OF HEALTH
Blood Resources Program

Limited Reinfusion Service Application

New York State Department of Health
Blood Resources Program
Wadsworth Center
Empire State Plaza
Albany, NY 12237

Facility/Site_____ **Phone** _____

Address _____ _____ _____ _____ _____
City State Zip County

Does this facility have a laboratory permit issued by the NYSDOH Clinical Laboratory Evaluation Program? ◯ Yes ◯ No

If yes, contact the Blood Resources Program at brp@health.ny.gov.

Services Offered ☐ Ambulatory Surgery ☐ Dentistry ☐ Medical Imaging ☐ Nuclear Pharmacy ☐ Podiatry

☐ Orthopedic Care ☐ Wound Care ☐ PMR Care ☐ Other_____

Owner _____ **Address**_____

Ownership ◯ Hospital-owned ◯ Practitioner-owned ◯ Other _____

Operating Certificate Number (If Article 28 facility) _____ ☐ N/A

Is this facility a small business (for profit, with fewer than 100 employees?) ◯ Yes ◯ No

Limited Reinfusion Service (LRS)
Director _____ **Title** _____

Phone _____ **E-mail Address** _____

LRS Contact Person _____ **Title** _____

Phone _____ **E-mail Address** _____

Processing ☐ Separation ☐ Radioisotopic labeling ☐ Immunologic manipulation ☐ Other_____

Reinfusion Products ☐ RBCs ☐ WBCs ☐ Plasma ☐ Platelet Gel ☐ Platelet-Rich Plasma

☐ Other _____

For platelet separation procedures, indicate system name/manufacturer_____

Administration Route ☐ IV ☐ Injection ☐ Topical ☐ Other _____

Facility Responsible for Preparation of the Reinfusion Product (if different)

Facility _____ **Phone** _____

Address _____ _____ _____ _____
City State Zip

I certify that I am authorized to submit this application and that the information provided is complete and accurate.

Name_____ **Title** _____
(Print) (Print)

Signature_____ **Date** _____

Please submit this application, along with the signed checklist attesting that policies and procedures that comply with 10 NYCRR, Section 58-2.27 are in place, to brp@health.ny.gov.