

Southern Area Blood Centre

Facility Application for FIRST Registration for Blood Services



Facility Details	Legal Name of Facility			
	Physical Address			
	<i>Town/City</i>		<i>Region</i>	
	Postal Address			
	Email			
	Telephone (s)			
	Head of Facility			
	Type of Facility	Ownership	Services Offered <i>(please tick as many as apply)</i>	
	<input type="checkbox"/> Clinic	<input type="checkbox"/> Government	<input type="checkbox"/> Gynaecological/Obstetric Surgery	
	<input type="checkbox"/> Polyclinic	<input type="checkbox"/> Quasi-Government	<input type="checkbox"/> General Surgery	
<input type="checkbox"/> Hospital	<input type="checkbox"/> CHAG	<input type="checkbox"/> Trauma/Ortho/Neuro/Urol/Cardiac Surgery		
<input type="checkbox"/> Regional Hospital	<input type="checkbox"/> Islamic	<input type="checkbox"/> Paediatric Medicine		
<input type="checkbox"/> Teaching Hospital	<input type="checkbox"/> Private	<input type="checkbox"/> Adult Medicine		
		<input type="checkbox"/> Oncology		

Contact	Contact Person	Title	Last Name	First Name
	Designation			Email
	Tel: (Office)		Tel: (Mobile)	

Transfusion Requirements	Number of Acute Care Beds:	Blood/Components Required
	Estimated Red Cell/Whole Blood Transfusions per month:	<input type="checkbox"/> Whole Blood
		<input type="checkbox"/> Concentrated Red Cells
		<input type="checkbox"/> Paediatric Units
	Service Required: <i>(please tick as many as apply)</i>	<input type="checkbox"/> Fresh Frozen Plasma
	<input type="checkbox"/> Screening services ONLY (microbial/serology)	<input type="checkbox"/> Random donor platelet concentrates
	<input type="checkbox"/> Cross-matched units	<input type="checkbox"/> Single donor platelet concentrates
<input type="checkbox"/> Bulk, uncross-matched units	<input type="checkbox"/> Cryoprecipitate	
Provide (approximate) date for Inspection of the Facility and Equipment as detailed in the Essential Resource List document:		Proposed Date for Inspection:

Name
Signature
Designation
Date

Official Use Only	Essential Resource List	Date Received	Fees Paid	Receipt Number	Date
	Facility Assessment	Assessors	Assessment (1)	Assessment (2)	Certificate Number:
	Blood Bank Training	Date Initiated	Date Completed	Certificate(s):	Certificate(s):
	Service Agreement	Date:	Other		