Greater Accra Regional Blood Centre

Facility Application for FIRST Registration for Blood Services

Facility Details

Legal Name of Facility			
Physical Address			
Town/City		*Region*	
Postal Address			
Email			
Telephone (s)			
Head of Facility			

Type of Facility	**Ownership**	**Services Offered** *(please tick as many as apply)*
☐ *Clinic*	☐ *Government*	☐ Gynaecological/Obstetric Surgery
☐ *Polyclinic*	☐ *Quasi-Government*	☐ General Surgery
☐ *Hospital*	☐ *CHAG*	☐ Trauma/Ortho/Neuro/Urol/Cardiac Surgery
☐ *Regional Hospital*	☐ *Islamic*	☐ Paediatric Medicine
☐ *Teaching Hospital*	☐ *Private*	☐ Adult Medicine
		☐ 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:	☐ Whole Blood
	☐ Concentrated Red Cells
	☐ Paediatric Units
Service Required: *(please tick as many as apply)*	☐ Fresh Frozen Plasma
☐ Screening services ONLY (microbial/serology)	☐ Random donor platelet concentrates
☐ Cross-matched units	☐ Single donor platelet concentrates
☐ Bulk, uncross-matched units	☐ 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		