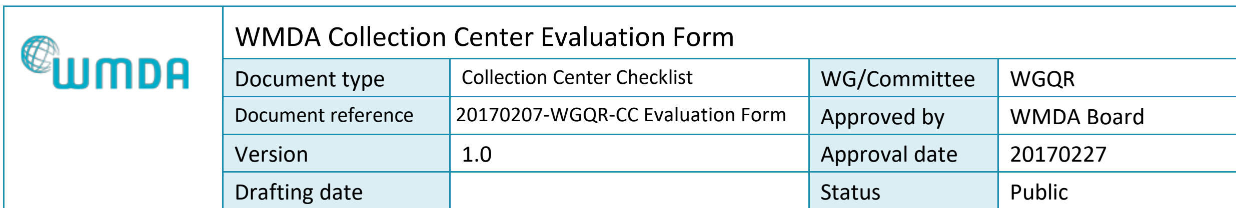

WMDA Collection Center Evaluation Form			
Document type	Collection Center Checklist	WG/Committee	WGQR
Document reference	20170207-WGQR-CC Evaluation Form	Approved by	WMDA Board
Version	1.0	Approval date	20170227
Drafting date		Status	Public

Please complete this form and return it signed by the Collection Center's Medical Director or their designee to (please fill in your name and e-mail or fax number):

Include all relevant documentation and reference it in the response to all relevant questions.
Please report any changes that occurred after (MM/YYYY):

Legal Name of Collection Center			
Address:			
City		Postal Code:	
Country:		Website:	
Office hours:			
Responsible Physician (Medical Director)			
Surname, first name:		Title:	
Address:			
City:		Postal Code:	
Country:		E-Mail:	
Telephone Number:		Fax Number:	
Contact Person (Coordinator)			
Surname, first name:		Title:	
Address:			
City:		Postal Code:	
Country:		E-Mail:	
Telephone Number:		Fax Number:	
Emergency Number:			
Please provide a copy of your current organigram.			
1. Please attach pick-up instructions for the blood sample couriers (pick-up address, contact person and contact data of this person, pick-up time)			

2. Please attach pick-up instructions for the stem cell product couriers		
3. The center is able to provide:		
☐ HPC, Bone Marrow		
☐ HPC, Apheresis		
☐ MNC, Apheresis		
☐ Buffy Coat		
☐ Other, please specify:		
5. Is your center FACT or JACIE accredited?		
☐ Yes (please provide a copy of the certificate)	☐ We currently apply for a FACT-JACIE accreditation and hope to get accredited by (MM/YYYY)	☐ No
6. Does your center have any other accreditations, licenses or certificates?		
☐ Yes, please specify (Please provide a copy of the certificate):		☐ No
7. Does your center have a quality management certificate?		
☐ Yes, please specify (Please provide a copy of the certificate):		☐ No
9. Please provide the license status of your own lab or a lab that has a service level agreement with your center for IDM testing: Please also provide a list of the current IDM profile and used methods and test kits.		
10. In case your center runs a processing lab, please provide their license status:		

Declaration

As the responsible (please tick the correct box) physician Medical Director I declare that the information provided on this form is complete, accurate and correct.

I will notify (fill in name and e-mail or fax number, where the information needs to be sent)

of any significant changes in personnel, facility or procedures that may have an impact on the activities of the Collection Center.

Date (MM/DD/YYYY): Signature: