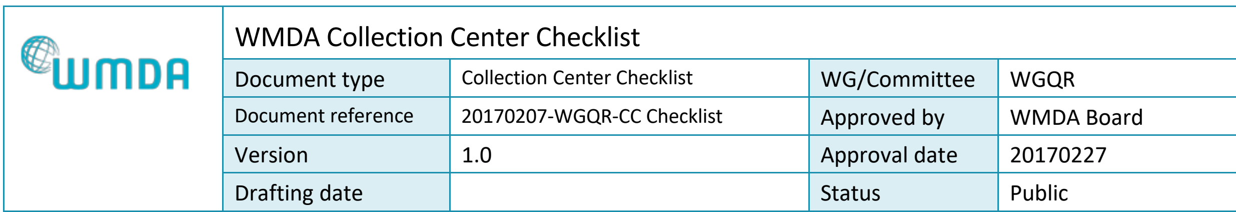

	WMDA Collection Center Checklist			
	Document type	Collection Center Checklist	WG/Committee	WGQR
	Document reference	20170207-WGQR-CC Checklist	Approved by	WMDA Board
	Version	1.0	Approval date	20170227
	Drafting date		Status	Public

Please complete this form and return it signed by the Collection Center's Medical Director or designee to (please fill in your name and email 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):

1. Were there any changes in your center's legal name?	
☐ No	☐ Yes, please specify:
2. Were there any changes in your center's address?	
☐ No	☐ Yes, please specify:
3. Did your medical director (or their designee, if a Medical Director is not in place) change?	
☐ No	☐ Yes, please specify:
4. Were there any changes in your key contact personnel?	
☐ No	☐ Yes, please specify:
If yes, please provide a copy of your current organigram.	
5. Were there any changes in your office hours?	
☐ No	☐ Yes, please specify:
6. Were there any changes in the pick-up instructions for the blood sample couriers?	
☐ No	☐ Yes, please specify:
If yes, please provide a copy of your current instructions.	
7. Were there any changes in the pick-up-instructions for the stem cell product couriers?	
☐ No	☐ Yes, please specify:

If yes, please provide a copy of your current instructions.

8. Is your emergency contact number still up-to-date?

☐ Yes	☐ No, please specify your new emergency contact number:

9. The center is able to provide:

☐ HPC, Bone Marrow

☐ HPC, Apheresis

☐ MNC, Apheresis

☐ Buffy Coat

☐ Other, please specify:

10. Were there any significant changes in your SOPs?

☐ No	☐ Yes (please specify and provide a copy of the updated SOPs)

11. 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

12. Were there any changes in your accreditations, licenses or certificates status?

☐ Yes, please specify and provide a copy of current certificates	☐ No

13. Does your center have a quality management certificate?

☐ Yes, please specify and provide a copy	☐ No

14. Were there any changes in your insurance status?

☐ No	☐ Yes, please specify:

15. In case the IDMs will be provided by your own lab or a lab that has a service level agreement with your center, are there any changes in their license status (If yes, please provide a copy of the current IDM profile, used methods and test kits)?	
☐ No	☐ Yes, please specify:
16. In case your center runs a processing lab, are there any changes in their license status?	
☐ No	☐ Yes, please specify:

Declaration

As the responsible (please tick 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 processes that may have an impact on the activities of the Collection Center.

Date: Signature: