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**APPLICATION FORM FOR LICENSING BLOOD FACILITIES AND BLOOD PRODUCTS LISTING**  
*(To be submitted in duplicate electronic copies. Please complete all relevant sections)*

Cover letter addressed to:

THE CHIEF EXECUTIVE  
FOOD AND DRUGS AUTHORITY  
P. O. BOX CT 2783  
CANTONMENTS-ACCRA  
GHANA.

All information sought in this form shall be provided to enable the FDA to process the application

**SUBMISSION SHOULD ALWAYS BE DONE BY A COMPETENT TECHNICAL OFFICER**

**Section 1 – Background Information**

**Reasons for submission**


Fresh Application	
Application renewal	

\*tick appropriately ( ✓ )

If the blood facility making the application already holds or has previously held a license from the FDA please enter the license number(s) below

Year of issuance:		License number:	
Year of issuance:		License number:	

**Section 2 – Applicant Details**


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**TYPE OF OWNERSHIP**

- SOLE PROPRIETORSHIP ☐
PARTNERSHIP ☐
- CORPORATION PROFIT ☐ / NON-PROFIT ☐
COOPERATIVE ASSOCIATION ☐
- HOSPITAL (Religious body) ☐
GOVERNMENT HOSPITAL ☐
- PRIVATE HOSPITAL ☐
- OTHER (Specify) \_\_\_\_\_

<b>Applicant:</b>	
<b>Legal name of blood facility:</b>	
<b>Other names used:</b> <i>(include trade name, doing-business-as, previous names, etc.)</i>	
<b>Trading as:</b>	
<b>Mailing address of applicant:</b> <i>(Include location of the post office)</i>	
<b>Physical Address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Telephone:</b>	
<b>Email:</b>	

<b>Contact person's information</b>
-------------------------------------

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<b>Name:</b>	
<b>Email:</b>	
<b>Telephone:</b>	

If you are an agent applying on behalf of the proposed license holder,  
Please tick here ☐

**Contact details for communications (if different from above)**


<b>Contact person's name:</b>	
<b>Company name:</b>	
<b>Telephone:</b>	
<b>Mobile:</b>	
<b>Email:</b>	
<b>Contact person's signature:</b>	

**Please note – this application form is divided into nine sections. Sections 1 and 2 and the final section 10 must only be completed once per licensure being applied for.**


**For sections 3 – 9 one set of these sections must be completed for each site that the applicant wishes to include on the license being applied for e.g. if the application is to cover two sites, two sets of sections 3 – 9 must be submitted, one for each site.**

**The requirement to submit a separate set of sections 3 – 9 for each site applies to contract sites also. Please make additional copies of Sections 3 – 9 as necessary to ensure you provide FDA with one set of sections 3 – 9 per site.**

**Section 3 - Product listing: Products manufactured and / or stored at the Site**

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<p align="center"><b>Please specify by ticking in the box</b></p> <p><input type="checkbox"/> Manufacture</p> <p><input type="checkbox"/> Storage</p> <p><input type="checkbox"/> Whole blood</p> <p><input type="checkbox"/> Red Blood Cells</p> <p><input type="checkbox"/> Fresh Frozen Plasma</p> <p><input type="checkbox"/> Platelets</p> <p><input type="checkbox"/> Cryoprecipitate</p> <p><input type="checkbox"/> Frozen RBC</p> <p><input type="checkbox"/> Washed RBC</p> <p><input type="checkbox"/> Leukocytes</p> <p><input type="checkbox"/> Leukoreduced RBC</p> <p><input type="checkbox"/> Recovered Plasma</p> <p><input type="checkbox"/> Irradiated Blood</p> <p><input type="checkbox"/> Fibrin Glue</p> <p><input type="checkbox"/> Granulocytes</p> <p><input type="checkbox"/> Buffy coats</p> <p><input type="checkbox"/> Serum Albumin</p> <p><input type="checkbox"/> Coagulation factors</p> <p><input type="checkbox"/> Immunoglobulins</p> <p><input type="checkbox"/> Other (Please specify): _____</p>
--

 <p><b>FOOD AND DRUGS AUTHORITY</b></p>	<p><b>DOC. TYPE: FORM</b></p> <p><b>DOC NO.: FDA/VBP/FOR – 30</b></p> <p>Page 5 of 16      Ver. No.:03</p> <p><b>Effective Date: 05/09/2025</b></p>	
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## Section 4 – Site Information


### TYPE OF BLOOD FACILITY (Check appropriate type)

- ☐ Regional Blood Centre  
☐ Community (Non-hospital) Blood bank  
☐ Product Testing Laboratory  
 a) \_\_\_\_\_ Independent  
 b) \_\_\_\_\_ Associated with community or hospital blood bank

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Hospital Blood bank   |
| <input type="checkbox"/> | Hospital Transfusion Service  |
| <input type="checkbox"/> | Donor Center  |
| <input type="checkbox"/> | Perioperative Autologous Collection / Administration                  |
| <input type="checkbox"/> | Plasmapheresis Centre   |
| <input type="checkbox"/> | Component Preparation Facility  |
| <input type="checkbox"/> | Hematopoietic Progenitor Cells (HPC)                                  |
| <input type="checkbox"/> | Cord Blood Processing   |
| <input type="checkbox"/> | Collection Centre   |
| <input type="checkbox"/> | Blood Distribution only   |
| <input type="checkbox"/> | Blood Storage Only  |
| <input type="checkbox"/> | Emergency Transfusion only (Ambulatory Surgery Centre)                |
| <input type="checkbox"/> | Industrial Manufacturer (whole blood/ plasma for further manufacture) |
| <input type="checkbox"/> | Other (specify): _____  |

**Please make additional copies of this section as required**


<b>Site Number:</b>	
---------------------	--

 <p><b>FOOD AND DRUGS AUTHORITY</b></p>	<p><b>FOOD AND DRUGS AUTHORITY</b></p>		<p><b>DOC. TYPE: FORM</b></p>	
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<b>Site Name:</b>	
<b>Site Address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Site contact person's name:</b>	
<b>Telephone:</b>	
<b>Mobile:</b>	
<b>Email:</b>	

<p><b>SITE ACTIVITY</b> – Please detail below site activity for clarity. Please indicate ‘Yes’ or ‘No’ against each proposed activity type</p>	
	<b>YES / NO</b>
Collecting blood	
Testing blood	
Processing whole blood into blood components	
Packaging and labelling	
Storage of whole blood, blood components and blood products	
Further Manufacture	
Release and Distribution of whole blood (ref Section 8)	
Distribution of blood components (ref Section 8)	

## Section 5 – Site Processes


 <p><b>FOOD AND DRUGS AUTHORITY</b></p>	<p><b>FOOD AND DRUGS AUTHORITY</b></p>		<b>DOC. TYPE: FORM</b>	
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<b>Site name:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Site number:</b>	

***Please make additional copies of this section as required***


**Processes conducted at this Site** - Please indicate 'Yes' or 'No' as required in the relevant column for each of the processes proposed to be conducted

	<b>YES / NO</b>
<b>WHOLE BLOOD COLLECTION SERVICES</b>	
<p align="center"><b>Please specify by ticking in the box</b></p> <p><input type="checkbox"/> On-Site</p> <p><input type="checkbox"/> Mobile Site</p> <p><input type="checkbox"/> Allogeneic</p> <p><input type="checkbox"/> Autologous whole blood collection</p> <p><input type="checkbox"/> Family replacement</p>	
<b>APHERESIS</b>	
<p align="center"><b>Please specify APHERESIS component type collected by ticking in the box</b></p> <p><input type="checkbox"/> Plasmapheresis</p> <p><input type="checkbox"/> Leukapheresis</p> <p><input type="checkbox"/> Plateletpheresis</p> <p><input type="checkbox"/> Erythrocytapheresis</p>	
<b>PROCESSING WHOLE BLOOD INTO:</b>	

 <p><b>FOOD AND DRUGS AUTHORITY</b></p>	<p><b>FOOD AND DRUGS AUTHORITY</b></p>		<p><b>DOC. TYPE: FORM</b></p>	
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<p style="text-align: center;">Please specify by ticking in the box</p> <p><input type="checkbox"/> Red Blood Cells</p> <p><input type="checkbox"/> Fresh Frozen Plasma</p> <p><input type="checkbox"/> Platelets</p> <p><input type="checkbox"/> Cryoprecipitate</p> <p><input type="checkbox"/> Frozen RBC</p> <p><input type="checkbox"/> Washed RBC</p> <p><input type="checkbox"/> Leukocytes</p> <p><input type="checkbox"/> Leukodepleted RBC</p> <p><input type="checkbox"/> Recovered Plasma</p> <p><input type="checkbox"/> Irradiated Blood</p> <p><input type="checkbox"/> Fibrin Glue</p> <p><input type="checkbox"/> Granulocytes</p> <p><input type="checkbox"/> Buffy coats</p> <p><input type="checkbox"/> Other (Please specify): _____</p>
<p><b>TESTING OF DONOR SAMPLES</b></p>
<p>Please specify by ticking in the box</p> <p><u>Testing (Routine)</u></p> <p><input type="checkbox"/> ABO</p> <p><input type="checkbox"/> Rh</p> <p><input type="checkbox"/> Antibody detection</p> <p><input type="checkbox"/> Antibody ID</p> <p><input type="checkbox"/> Cross matching</p> <p><u>Testing (Special)</u></p>



 <p><b>FOOD AND DRUGS AUTHORITY</b></p>	<p><b>FOOD AND DRUGS AUTHORITY</b></p>		<p><b>DOC. TYPE: FORM</b></p>	
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<input type="checkbox"/> HBsAg <input type="checkbox"/> HBcAb <input type="checkbox"/> HIV I / II <input type="checkbox"/> HTLV-I / II <input type="checkbox"/> HCV <input type="checkbox"/> Syphilis <input type="checkbox"/> NAT Testing
--


## Section 5 – Site Processes (continued)

<b>Site name:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Site number:</b>	

**Please make additional copies of this section as required**

## *Processes conducted at this Site (continued)*

<b>COMPONENTS PROCESSED INTO:</b>	<b>YES /NO</b>
Methylene blue treated plasma	
Irradiated components	
Washed components	
Splitting into small volume packs	

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Pooling cryoprecipitate	
Haematocrit determination	
Other (please specify):	

### Section 5 – Site Processes (continued)


#### OTHER PROCESSES

<b>SITE NAME:</b>	<b>SITE ADDRESS:</b>
<div style="margin-top: 10px;"> <input type="checkbox"/> Manufacturer  <input type="checkbox"/> Ambulatory Surgery Centre  <input type="checkbox"/> Dialysis Service  <input type="checkbox"/> Plasmapheresis Centre  <input type="checkbox"/> Other, (Please Specify):  <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> </div>	

### Section 6 – Site Personnel

Please provide information, including name(s) of responsible person(s) involved in the operational activities for **this site**.

Legal name of responsible person	Designation / Qualification	Contact information (Tel. phone and Email)

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For each person named above a copy of section 7 of this form must be submitted.


### Section 7 – Responsible person - Details

<b>Site name:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Site number:</b>	
<b>Signature of responsible person</b>	

Please make additional copies of this section as required

**Note.** All applications for a person to be nominated as a responsible person in a blood facility must be signed by both the **APPLICANT** and the **RESPONSIBLE PERSON**.

Nominee as a Responsible Person	
Title:	
First name(s):	
Surname:	
Business Address:	
Telephone:	
Mobile:	
Email:	

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<b>Designation</b> – tick as appropriate the designation of the nominated responsible person at the site			
Permanent employee		Consultant	


<b>Consultant</b> – If consultant was ticked above	
What is the distance from your base to site?	(miles)
How frequently will you visit the site?	
Briefly specify below what are your arrangements for dealing with routine and urgent activities when you are not at the site?	

### Section 7 – Responsible Person– Details (continued)

<b>Site name:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Postal address:</b>	
<b>Site number:</b>	

**Please make additional copies of this section as required**

<b>Qualifications</b> – enter in the box below details of your educational qualifications
---


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**Experience** – enter in the box below details of your practical post-graduate experience relevant to the responsibilities of a Responsible Person for at least 2 years in at least a blood facility licensed / authorized in Ghana

I confirm that the above particulars are to the best of my knowledge and belief and are complete, accurate and true.

Signed (Nominated person): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name (Nominated person): \_\_\_\_\_

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Signed (Applicant): _____ Date: ____/____/____
Print Name (Applicant): _____


### Section 8 – Other blood facilities and Hospitals supplied

<b>Site name:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Postal address:</b>	
<b>Site number:</b>	

**Please make additional copies of this section as required**

### DETAILS OF OTHER BLOOD FACILITIES AND HOSPITALS SUPPLIED WITH BLOOD/BLOOD COMPONENTS/BLOOD PRODUCTS

<b>Legal name of hospital / blood facility:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Postal address:</b>	
<b>Responsible Regional Blood Centre:</b>	

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<b>Legal name of hospital / blood facility:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Postal address:</b>	
<b>Responsible Regional Blood Centre:</b>	

If further copies of this table are made, please provide the **TOTAL** number of facilities supplied with blood/ components by your facility:


### Section 9 - Further information

<b>Site name:</b>	
<b>Physical address:</b> <i>(Include legal name, number, street, city, and district)</i>	
<b>Postal address:</b>	
<b>Site number:</b>	

**Please make additional copies of this section as required**

### Facilities on Site

•On a separate sheet of paper, please provide a brief description (approximately 500 words each) of the facilities available for the **collection, testing, processing, storage, release** and **distribution** of whole blood, blood components and blood products.

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**Additional Information**

•You are invited to provide any other information that may support your application in the space below

**Section 10 - Declaration**

I/we apply for the license for a blood facility to the proposed holder named in this application form in respect of the activities to which the application refers.  
I declare that the information provided with this application is complete and correct.  
  
**Signed:** \_\_\_\_\_  
  
**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
  
**Print name (Block Capital):** \_\_\_\_\_  
  
**State capacity in which signed:** \_\_\_\_\_