

**Hospital Information:**

Hospital Name:
Hospital Address:

**Form Completed by:**

Name/Title:	Phone Number:
Date:	E-mail:

Please send the completed survey to CBC by email to the originating CBC staff or:

- **By Mail/Courier:**  
Community Blood Center  
ATTN: Quality/Regulatory Affairs  
349 South Main Street  
Dayton, OH 45402-2715
- **By Email** to [supplierqualification@cbccts.org](mailto:supplierqualification@cbccts.org)
- **Call** with any questions: 800-684-7783

Section 1: General Information				
1.1	Does your facility continuously monitor and record the temperature of all blood product storage devices, including platelet storage locations, or do you record the temperature at least every four (4) hours if continuous monitoring is not available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.2	Does your facility have qualified storage and transport devices with the capacity and design to ensure the proper temperature of blood products is maintained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.3	Are blood products stored in other areas of your facility? (e.g., emergency room, surgical or obstetric suites)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.4	Do all your facility's blood product storage devices have alarms to warn of temperature deviations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	• Are the alarms set to activate under conditions that will allow immediate action to be taken before the blood products reach unacceptable conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
	• Does the activation of the alarm initiate a process for immediate investigation and appropriate corrective action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
1.4	• Is the alarm audible and monitored 24 hours a day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
1.5	Does your facility have written procedures to ensure blood products are not removed from validated storage and/or transport devices for more than 30 minutes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.6	Does your facility have written procedures for the storage and handling of blood products to prevent damage and limit deterioration in the case of storage unit malfunction or power failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.7	Are all blood product storage units on emergency power?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.8	Does your facility have a quality control program to ensure blood product storage and transport devices, including platelet incubators & rotators, function as expected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.9	Does your facility have a written procedure for handling blood products that are outdated, leaking, broken, discolored, or have an unusual appearance, and are visual inspections performed at pre-determined points in your processes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

1.10	Is access by unauthorized personnel limited in your blood bank/laboratory or other blood product storage areas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.11	Are the procedures and other records referenced in this assessment available for review by CBC if needed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1.12	Please explain any "No" or N/A" answers in Section 1.			

**Section 2: Licensure/Certification**

2.1	Agency	Registration #	Exp. Date	Date of Last Inspection	Were there any findings?		
	AABB				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
	CAP				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
	HFAP				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
2.2	Please include copies of the applicable registrations listed above.						<input type="checkbox"/> NA
2.3	If there were any findings noted during the inspection of one of the agencies listed above, please attach an explanation of: <ul style="list-style-type: none"> <li>• The nature of the finding</li> <li>• A description of the corrective action plan</li> <li>• Confirmation that the corrective action was effective and that the issue has been resolved.</li> </ul>						

**Section 3: CBC Approval**

3.1	Are all responses and supporting documentation acceptable?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.2	Comments:				
3.3	CBC Approval:				
	QRA Review/Date:				