

1. Date: _____
2. Facility Name: _____
3. Facility Type: _____

4. Contact Name: _____
5. Title: _____
6. Address: _____

7. Phone 1: _____
8. Phone 2: _____
9. Fax: _____
10. Email: _____
11. Website: _____

For Hospitals:

1. Births per year: _____
2. NICU Level: _____
3. NICU Beds #: _____
4. Chief fo Neonatology: _____
5. Phone: _____
6. Chief of Obstetrics: _____
7. Phone: _____
8. Director of OB/Nursing: _____
9. Phone: _____

Please Mark all of the following that apply:

- Would like a call back from a representative
- Would like program literature sent for review
- Would like to set-up a presentation

For CHS Use Only: Date Received: _____ Account Manager: _____ Notes: _____ _____
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Instructions: For Facilities interested in hosting a milk bank, please complete all of the requested information below and fax back to (818)865-2432. For questions, please call (877)215-8500.

For All Facilities:

1. How did you find out about hosting a milk bank: _____
2. How many potential donors do you anticipate having each month: _____
3. How many donated ounces do you anticipate collecting each month: _____
4. Do you have an approximately 100 sq. foot area to store milk bank equipment: _____
5. How many milk bank staff members do you anticipate having: _____
6. Do you have access to a blood drawing facility: _____
7. Do you currently have a Tissue Bank license for human milk: _____
8. If so, in which state: _____
9. Are you available for a conference call to discuss further details: _____
10. If so, when: _____
11. What date would you be ready to set-up a milk bank: _____

Comments: _____
