From: [redacted]
To: APHIS-AnimalCare
Subject: Application for Registration_RegistrationRenewal_Pharmgate Biologics Inc.
Date: Tuesday, December 15, 2020 2:00:17 PM
Attachments: Application for Registration_Pharmgate Biologics Inc..pdf

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Hello,

Please find attached the application for our Animal Welfare Registration renewal. Please let me know if you have any questions or need any further information.

[redacted]
office: 612.256.0930, ext [redacted]
St. Paul, MN 55114 | pharmgate.com
Pharmgate BIOLOGICS

Every research facility, exhibitor, carrier, and intermediate handler not required to be licensed under Section 3 of the Animal Welfare Act, shall register with the USDA (7 USC 2136). This application provides information for such registration.

OMB No. 0579-0036
FORM APPROVED

U.S. DEPARTMENT OF AGRICULTURE
ANIMAL AND PLANT HEALTH INSPECTION SERVICE

APPLICATION FOR REGISTRATION

(TYPE OR PRINT)

REGISTRATION UPDATE

USDA USE ONLY

Applicant should send completed form to this address.
USDA APHIS ANIMAL CARE
EASTERN
2150 Centre Ave.
Building B, Mailstop #3W11
Fort Collins, CO 80526-8117
(970) 494-7478

CERTIFICATE NO./CUST NO:	RENEWAL DATE

1. REGISTRANT *(Name and permanent mailing address, including Zip Code)*
Pharmgate Biologics Inc.
2575 University Ave. W, Suite 100
Saint Paul, MN 55114

COUNTY: RAM TELEPHONE

2. LOCATION (S) OF BUSINESS, EXHIBITION SITE(s), OR RESEARCH FACILITIES *(Use additional sheets if necessary)*
2575 University Ave. W (b) (7)(F)
Saint Paul, MN
55114

3. (A) PREVIOUS USDA REGISTRATION NUMBER (IF ANY)

4. (B) ACTIVE USDA CERTIFICATE NUMBER(S) IN WHICH YOU HAVE AN INTEREST:

5. ARE YOU USING FEDERAL FUNDS TO CARRY OUT RESEARCH, TESTS, OR EXPERIMENTS
☐ Yes ☒ No

6. TYPE OF REGISTRATION:
◇ Class E – Exhibitor ◇ Class H – Intermediate Handler
Class R – Research Facility ◇ Class T - Carrier

7. FEDERAL FUND TYPES:
◇ Award ◇ Contract ◇ Grant ◇ Loan

8. TYPE OF ORGANIZATION:
◇ Partnership ◆ Corporation ◇ Individual
◇ Other *(Specify)* _____

9. IF INDIVIDUAL IDENTIFY EACH OWNER, IF PARTNERSHIP IDENTIFY EACH PARTNER OR OFFICER, IF CORPORATION, IDENTIFY PRINCIPAL OFFICERS FOR RESEARCH FACILITIES INCLUDE THE INSTITUTIONAL OFFICIAL (Use separate sheet if needed)

A. NAME	B. TITLE	C. ADDRESS *(full address, including ZIP Code)*
(b) (6), (b) (7)(C)		2575 University Ave. W, Suite 100 Saint Paul, MN 55114

CERTIFICATION

I hereby register as a Research Facility, Exhibitor, Carrier, or Intermediate Handler under the Animal Welfare Act, 7 U.S.C. 2131 et seq. and I certify that the information provided herein is true and correct to the best of my knowledge. I hereby acknowledge receipt of and agree to comply with all the regulations and standards contained in 9 CFR, Subpart A, parts 1, 2 and 3. I certify that all listed persons are 18 years of age or older.

10. SIGNATURE	11. TITLE (Please print)	12. DATE SIGNED
(b) (6), (b) (7)(C)	I.O., VP Biologics	12/15/2020

APHIS FORM 7011
(FEB 2009)

ACKNOWLEDGEMENT OF RECEIPT OF REGULATIONS AND STANDARDS

STATE: CUSTOMER #:

IMPORTANT

THE FEDERAL DEBT COLLECTION ACT of 1996 requires us to obtain your Federal Taxpayer Identification Number (FTIN). This would be either your Federal Employer Identification Number (EIN) or your Social Security Number(s) (SSN's).

This number is for the purpose of collecting and reporting any delinquent amounts arising out of a relationship with the federal government.

Our computer system will not allow processing of your application or renewal without this number.

You must submit your SSN or EIN number in the appropriate space below. If the number submitted does not match your previously submitted number, you will be contacted for clarification.

If you change the SSN, Tax Id Number, and /or Type of Organization we have on file, you may have to apply for a new License/Registration.

Thank you for your cooperation.

If Type of Organization is Corporation, Partnership (with an EIN), or Other, please fill out A ***or*** B

A. Corporation Name: Pharmgate Biologics Inc.
EIN: 41-1507830

B. Partnership Legal Name: _____
EIN: _____

If Type of Organization is Individual or Partnership (with SSNs), please fill out either C ***or*** D

C. Individual: Name: _____ SSN: ___ __ ____

D. Partnership:
Partner Name: _____ SSN: ___ __ ____
Partner Name: _____ SSN: ___ __ ____
Partner Name: _____ SSN: ___ __ ____
Partner Name: _____ SSN: ___ __ ____

August 25, 2014
21-02162_000157