

MEDICAL SUPERINTENDENT OFFICE GURU GOBIND SINGH HOSPITAL, FARIDKOT



Sadiq Road, Faridkot-151203 (Pb.) Indian

Ph. No. 01639-250098

Email- msggshospital@gmail.com

No. Pur/2021/ 17565

Date:- 01/11/21

IT Cell
BFUHS, Faridkot (for uploading on website)

Sub:- Quotations for Purchase of Sticker For Blood Bank

Sealed quotations are invited for purchase of following items on the terms & conditions mentioned below:-

Sr. No.	Name of the item	Quantity Required
1	Component's Group Label Sticker (Size 3.5"x5") (Sample Enclosed)	As per enclosed list


Terms & Conditions:-

- Payment : By Cheque/RTGS
- On receipt of material in good condition.
 - On receipt of material satisfactory report from the Concerned Deptt./Store.
- F.O.R : Store Section, GGS MH, Faridkot.
- Rate : 1. Taxes (as applicable), if any, be mentioned separately in the quotation.
2. The rates of taxes, be charged as per prevailing Govt. Notified Schedule.
- Quantity/Item : Quantity may increase or decrease.
- Others : 1. The firm should have PAN No, GST No and Bank Account No.
2. The material should be as per enclosed specifications.
3. The final decision of branded item would be reserves to consumer/concerned deptt.

You are therefore requested to quote your lowest rates of above items and submit Quotations addressed to "**The Medical Superintendent, Guru Gobind Singh Medical Hospital, Faridkot (Punjab)**". The words "**Quotations for Purchase of Sticker**" may please be inscribed on top of the envelope.

The Medical Superintendent reserves the right to reject the quotations without assigning any reason.

The sealed quotations should reach this office on or before 08/11/21 by 5.00 PM through **Registered/Speed Post/Traceable Courier** only.


Medical Superintendent

- Notice Board.

DEPT. OF IH&BT (BLOOD BANK) GGS MC HOSPITAL FARIDKOT

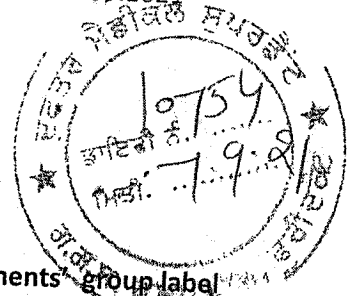
NO. BB/2021/ 619

Dated: 06.09.2021

To,

The Medical Supdt.
GGS MC&H
Faridkot.

M.S. Branch. ...
Office Supdt. Date.....



Subject:- Supply of Components' group label stickers (Size 3.5"x5"each).

Sir,

With reference to the subject, it is stated that kindly supply following Components' group label stickers at the earliest, so that these can be utilised for Components' Units & compliance as per Drugs & Cosmetic Act, 1940 and rules, 1945 can be shown at the time of Inspection (Specimen copy of each Group is attached).

Sr.No.	Blood group	Type of Components Unit	Quantity
1.	A+ve	Fresh Frozen Plasma B.P on white paper with Group in Yellow colour	150
2.	A-ve	Fresh Frozen Plasma B.P on white paper with Group in Yellow colour	50
3.	A+ve	Platelet Concentrate / PRP USP on white paper with Group in Yellow colour	400
4.	A-ve	Platelet Concentrate / PRP USP on white paper with Group in Yellow colour	100
5.	B+ve	Fresh Frozen Plasma B.P on white paper with Group in Pink colour	150
6.	B-neg	Fresh Frozen Plasma B.P on white paper with Group in Pink colour	50
7.	B+ve	Platelet Concentrate / PRP USP on white paper with Group in Pink colour	400
8.	B-neg	Platelet Concentrate / PRP USP on white paper with Group in Pink colour	100
9.	O+ve	Fresh Frozen Plasma B.P on white paper with Group in Blue colour	150
10.	O-neg	Fresh Frozen Plasma B.P on white paper with Group in Blue colour	50
11.	O+ve	Platelet Concentrate / PRP USP on white paper with Group in Blue colour	400
12.	O-neg	Platelet Concentrate / PRP USP on white paper with Group in Blue colour	100
13.	AB+ve	Fresh Frozen Plasma B.P on white paper with reversed print of Group	150
14.	AB-neg	Fresh Frozen Plasma B.P on white paper with reversed print of Group	50
15.	AB+ve	Platelet Concentrate / PRP USP on white paper with reversed print of Group	400
16.	AB-neg	Platelet Concentrate / PRP USP on white paper with reversed print of Group	100

[Signature]
Prof & Head,
IH & BT(Blood Bank),
GGS MC & H, Faridkot.

GGS MEDICAL COLLEGE HOSPITAL FARIDKOT
DEPT. OF IH & BT(BLOOD BANK LICENSE NO.1602-B)

FRESH FROZEN PLASMA B.P.

Prepared from 350/450 ml whole Blood collected in 49/63 ml CPDA1 sol.

VOLUNTARY DONOR

BLOOD GROUP **A** Rh Positive

Blood Bag No. _____ Collection Date _____
Tube segment No. _____ Expiry Date _____

Non Reactive for HIV 1&2, HbsAg, HCV, VDRL & Neg. For MP

Cross matched for Patient _____
CR No. _____ Ward _____ Dr I/c _____
Hospital _____ on Dated _____

Sign. _____

INSTRUCTIONS :

1. Examine contents and Check the Labels before use.
2. Store below --30° C
3. Thaw at 37° C & Use as early as possible.
4. Mix thoroughly before use.
5. Administer Group compatible.
6. Use disposable sterile transfusion set with filter.
7. Do not use if any visible evidence of deterioration.

GGS MEDICAL COLLEGE HOSPITAL FARIDKOT
DEPT. OF IH & BT(BLOOD BANK LICENSE NO.1602-B)

PLATELET CONCENTRATE/PRP U.S.P

Prepared from 350/450 ml whole Blood collected in 49/63 ml CPDA1 sol.

VOLUNTARY DONOR

BLOOD GROUP **A** Rh Positive

Blood Bag No. _____ Collection Date _____
Tube segment No. _____ Expiry Date _____

Non Reactive for HIV 1&2, HbsAg, HCV, VDRL & Neg. For MP

Cross matched for Patient _____
CR No. _____ Ward _____ Dr I/c _____
Hospital _____ on Dated _____

Sign. _____

INSTRUCTIONS :

1. Examine contents and Check the Labels before use.
2. Store between 20°-24° C
3. Use as early as possible.
4. Mix thoroughly before use.
5. Administer Group compatible.
6. Use disposable sterile transfusion set with filter.
7. Do not use if any visible evidence of deterioration.

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VOLUNTARY DONOR

BLOOD GROUP A Rh Negative

Blood Bag No. _____ Collection Date _____
Tube segment No. _____ Expiry Date _____

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CR No. _____ Ward _____ Dr I/c _____
Hospital _____ on Dated _____

Sign. _____

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VOLUNTARY DONOR

BLOOD GROUP **B** Rh Positive

Blood Bag No. _____ Collection Date _____

Tube segment No. _____ Expiry Date _____

Non Reactive for HIV 1&2, HbsAg, HCV, VDRL & Neg. For MP

Cross matched for Patient _____

CR No. _____ Ward _____ Dr I/c _____

Hospital _____ on Dated _____

Sign. _____

INSTRUCTIONS :

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2. Store below -30°C
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4. Mix thoroughly before use.
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Prepared from 350/450 ml whole Blood collected in 49/63 ml CPDA1 sol.

VOLUNTARY DONOR

BLOOD GROUP **B** Rh Positive

Blood Bag No. _____ Collection Date _____

Tube segment No. _____ Expiry Date _____

Non Reactive for HIV 1&2, HbsAg, HCV, VDRL & Neg. For MP

Cross matched for Patient _____

CR No. _____ Ward _____ Dr I/c _____

Hospital _____ on Dated _____

Sign. _____

INSTRUCTIONS :

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Tube segment No. _____ Expiry Date _____

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BLOOD GROUP **AB** Rh Positive

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