# APPLICATION FOR INITIAL CLINICAL LABORATORY LICENSE FOR LABORATORIES LOCATED IN STATES OTHER THAN CALIFORNIA

Refer to California Business and Professions Code, Division 2, Chapter 3

**Instructions:** Complete both pages of this application and return with the required information and fee to:

California Department of Public Health
Laboratory Field Services
850 Marina Bay Parkway, Bldg. P 1st Floor
Richmond, CA 94804

1. Please choose one of the following options:
   - ☐ I choose to register for state oversight.
   - ☐ I choose deemed status with the following accrediting organization approved by the California Department of Public Health:

     ☐ CAP ☐ COLA ☐ The Joint Commission (JC)

     Note: If you choose deemed status, please provide a copy of your current certificate of accreditation, or a letter of acknowledgement from the accrediting organization that you have applied.

| 2. Name of Laboratory | | | Tax ID Number | |
|---|---|---|---|---|
| Address (number, street, suite/apt) | City | County | State | Zip Code |
| Telephone Number ( ) | Fax Number ( ) | Email Address | | |

| 3. CLIA provider number 05D_____ | 4. State the number of testing sites for this CLIA number_____. If there is more than one, complete form B. |
|---|---|

5. Legal name of corporation, district, or association owning laboratory (Fictitious name permit must be on file; provide name of locality where permit is filed)

_____

6. Select type of ownership. Check (✓) and complete the name and address (Section 1211 of Business Professions Code).

   - ☐ Individual
   - ☐ Partnership (general or limited). List name(s) and address(s) of all members of the partnership. Use supplementary sheet if necessary.
   - ☐ Corporation. List names of officers, directors, shareholders holding a 5% interest in the corporation, and any person, partnership, or corporation who or which has the responsibility to manage or conduct the day-to-day operation of the laboratory. (Use supplementary sheet if necessary.)
   - ☐ Unincorporated Association
   - ☐ District, City, County, or State
   - ☐ Other (specify) (if nonprofit, submit proof of nonprofit status):_____

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Name | Address | City | State | Zip Code |
| Name | Address | City | State | Zip Code |
| Name | Address | City | State | Zip Code |
| Name | Address | City | State | Zip Code |
| Name | Address | City | State | Zip Code |

7. Laboratory Director(s) (M.D., D.O.)

| | | | | | Hour Per Week On Site |
|---|---|---|---|---|---|
| Name | Address (number, street) | City | State | Zip Code | |
| Name | Address (number, street) | City | State | Zip Code | |
| Name | Address (number, street) | City | State | Zip Code | |
| Name | Address (number, street) | City | State | Zip Code | |
| Name | Address (number, street) | City | State | Zip Code | |
| Name | Address (number, street) | City | State | Zip Code | |

8. Attach a copy of the most recent certification letter from CMS indicating all the specialties/subspecialties for which this laboratory is certified.

9. Attach a copy of the written procedure of each test methodology for which this laboratory is testing specimens that originate in California.

10. Attach a copy of the last survey report and the laboratory's plan of correction for any deficiencies cited.

11. Attach a copy of the proficiency testing results for the previous three (3) testing events.

12. Complete and return CMS 1513 Ownership form (copy of form submitted to state agency is acceptable).

13. Complete and return the enclosed Laboratory Personnel Report form with this application LAB 116 OS.

14. Complete and return the enclosed Laboratory Personnel Qualification form with this application for each person performing testing and all personnel responsible for test performance.

**This statement must be signed by the owner or a person legally authorized to bind the owner, and the laboratory director.**
**I declare that the foregoing statements are true and correct to the best of my knowledge and belief.**

| Laboratory Director Signature | Type or Print Name | Title | Date |
|---|---|---|---|
| Owner Signature | Type or Print Name | Title | Date |

**For application questions, email: lfsfacoutofstate@cdph.ca.gov**
**NOTE: State registration fees schedule: http://www.cdph.ca.gov/programs/lfs/Documents/A-License-FeeSchedules.pdf**
**Make checks payable to: California Department of Public Health**