

## APPLICATION-- CLINICAL LABORATORY REGISTRATION

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

Instructions: Use typewriter or print in ink. Complete both pages of this application and **return** with **required information** and **fee** to:

California Department of Public Health  
 Laboratory Field Services /ATT: Clinical Laboratory Registration  
 850 Marina Bay Parkway, Bldg. P, 1<sup>st</sup> Floor  
 Richmond, CA 94804-6403

For application questions, e-mail. LFSRecep@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**

Items 1-3 MUST agree with the information for the CLIA Provider number and on the application for a Medi-Cal Provider number .

1. Name of laboratory				Tax ID number	
Address (number, street)		City	County	State	ZIP code (include +4 digits)
Telephone number (     )	Fax number (     )	E-mail address			
2. CLIA provider number O5D _____			3. Type of certificate <input type="checkbox"/> Certificate of Waiver <input type="checkbox"/> Provider Performed Microscopic Procedure		
4. Legal name of corporation, district, or association owning laboratory (fictitious name permit must be on file—state the name of locality where permit is filed)					

5. Type of ownership. Check (✓) and complete name and personal address (Section 1211 of Business and Professions Code).

Individual

Name	Personal address (number, street)	City	State	ZIP code

Partnership (general or limited). List name(s) and address(es) of all members of the partnership. Use supplementary sheet if necessary.

Name	Personal address (number, street)	City	State	ZIP code
Name	Personal address (number, street)	City	State	ZIP code
Name	Personal address (number, street)	City	State	ZIP code

Corporation. State names of officers, directors, shareholders holding a 5% or more 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.)

Name	Personal address (number, street)	City	State	ZIP code
Name	Personal address (number, street)	City	State	ZIP code
Name	Personal address (number, street)	City	State	ZIP code
Name	Personal address (number, street)	City	State	ZIP code

Unincorporated association

Name	Personal address (number, street)	City	State	ZIP code

District, city, county, or state

Name	Personal address (number, street)	City	State	ZIP code
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Other (specify) (if nonprofit, submit proof of nonprofit status): \_\_\_\_\_

Name	Personal address (number, street)	City	State	ZIP code
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6. Laboratory Director(s) (M.D., D.O.)

Name	Personal address (number, street)	City	State	ZIP code	Hours Per Week On-site

**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 (M.D., D.O.)	Type or print name	Title	Date
Owner signature	Type or print name	Title	Date