

APPLICATION FOR PARTICIPATION IN THE CALIFORNIA BLOOD LEAD PROFICIENCY ASSURANCE PROGRAM

Please complete this form and return it by FAX or mail to:

California Department of Public Health
 Environmental Health Laboratory Branch
 Lead Poisoning Prevention Unit
 850 Marina Bay Parkway, MS G365/EHLB
 Richmond, CA 94804-6403
 (510) 620-2800 FAX: (510) 620-2825

CLIA ID number
_____ D _____

Laboratory name

Laboratory address (number, street)	City	State	ZIP code
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California Clinical Laboratory license number, laboratory registration number or approved Public Health Laboratory number

Contact person <i>(check one title)</i> <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Other	Name
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Telephone number and extension ()	Fax number ()	Services commercially available <input type="checkbox"/> Yes <input type="checkbox"/> No
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Commercial services contact person <i>(check one title)</i> <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Other	Name
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Telephone number and extension ()	Fax number ()	Medicare certified <input type="checkbox"/> Yes <input type="checkbox"/> No
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Method of analysis

(Please attach a copy of the analytical procedure used in your laboratory for blood lead analysis. This should be the same analytical method or protocol that is included in your Quality Assurance Manual.)

Minimum sample volume (mL)

Please confirm your participation in one or more of the following blood lead proficiency testing programs:

CAP Yes No CAP code number: _____ - _____ - _____

WSLH Yes No WSLH code number SL: _____

AAFP Yes No AAFP code number: _____

Indicate your choice of program results to be evaluated for proficiency *(check one)*: CAP WSLH AAFP

Signature of laboratory director	Printed name of laboratory director	Date
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