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, 1st 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	3. Type of certificate
O5D ____ ____ ____ ____ ____ ____ ____	☐ Certificate of Waiver ☐ 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

☐ Other (specify) *(if nonprofit, submit proof of nonprofit status)*: _____

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

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

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

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