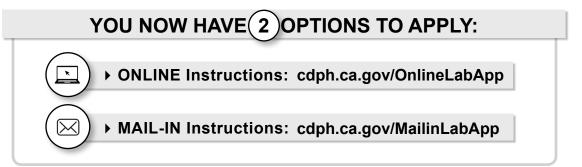
APPLICATION FOR INITIAL CLINICAL LABORATORY REGISTRATION

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



Name of Laboratory:

Legal Name of Corporation, district, or association owning laboratory (DBA):

(Submit fictitious name permit, provide name of locality where permit is filed)

CLIA ID: (leave bl	ank if applying)	Tax ID	(required)		Туре	e of Certificate F Waiver	Requested: PPMP	
Physical Address:			Mailing Address:					
Number, Street:				Number,	Street:			
Room/suite:				Room/sı	uite:			
City:	State	: Zip (Code:	City:		State:	Zip Code:	
Testing Site Contact Person:			Business Contact Person:					
Testing Site Email:				Business Email:				
Testing Site Phone:				Business Phone:				
LABORATORY	OVERSIGHT:							
STA	TE OVERSIGHT							
DEEMED STATUS* with the accrediting organization approved by the CDPH:								
*Su	AAHHS/HFAP bmit proof of enr	-	AABB or a copy o	CAP f the curr	COLA ent certifica		on.	
	Check #:		Amount:	AP	L -	STATE ID:		
OFFICE USE:								

OWNERSHIP					
Sole Proprietorship	NonProfit (Submit proof)	Other (specify):			
Limited Partnership (LP)	District				
General Partnership (GP)	City				
Limited Liability Partnership (LLP)	County				
Corporation	State				
Limited Liability Companies	Federal Government				
Unincorporated Association	Public Health				
% Owned: Name (Individual / Company):	Role:	Tax ID:			

(Use supplementary sheets if necessary and use the same format.)

LABORATORY DIRECTOR									
hrs/wk Name of Laboratory Director	License	License	Association						
on site: (First, Initial, Last):	Number:	Туре:	Date:						

(Use supplementary sheets if necessary and use the same format.)

Note:

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.

Signature of Laboratory Director:Print Name:Date:

Signature of Owner or Authorized Rep: Print Name: Date: