APPLICATION FOR INITIAL CLINICAL LABORATORY LICENSE

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 ☐ AABB ☐ 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	

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: LFSnewfaclic@cdph.ca.gov
NOTE: State registration fees schedule: https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/Fees.aspx
Make checks payable to: California Department of Public Health