

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION FOR CERTIFICATION

ALL APPLICABLE SECTIONS OF THIS FORM MUST BE COMPLETED.

**ALL ITEMS
HIGHLIGHTED IN
YELLOW ARE
REQUIRED FOR
THE APP TO
PROCESS**

I. GENERAL INFORMATION

<input checked="" type="checkbox"/> Initial Application Anticipated Start Date _____ <input type="checkbox"/> Survey <input type="checkbox"/> Change in Certificate Type <input type="checkbox"/> Other Changes (Specify) _____ Effective Date _____		CLIA IDENTIFICATION NUMBER _____ D _____ (If an initial application leave blank, a number will be assigned)	
FACILITY NAME ABC County Board of Education		FEDERAL TAX IDENTIFICATION NUMBER 12-12345678	
EMAIL ADDRESS contactname@gmail.com		TELEPHONE NO. (Include area code) (229) 111-1111	FAX NO. (Include area code) (229) 222-2222
<input checked="" type="checkbox"/> RECEIVE FUTURE NOTIFICATIONS VIA EMAIL FACILITY ADDRESS — Physical Location of Laboratory (Building, Floor, Suite if applicable.) Fee Coupon/Certificate will be mailed to this Address unless mailing or corporate address is specified NUMBER, STREET (No P.O. Boxes) 123 Street		MAILING/BILLING ADDRESS (If different from facility address) send Fee Coupon or certificate NUMBER, STREET _____	
CITY Beverly Hills	STATE GA	ZIP CODE 90210	CITY _____
SEND FEE COUPON TO THIS ADDRESS PICK ONE: <input checked="" type="checkbox"/> Physical <input type="checkbox"/> Mailing <input type="checkbox"/> Corporate	SEND CERTIFICATE TO THIS ADDRESS PICK ONE: <input checked="" type="checkbox"/> Physical <input type="checkbox"/> Mailing <input type="checkbox"/> Corporate	CORPORATE ADDRESS (If different from facility) send Fee Coupon or certificate CITY _____	NUMBER, STREET _____ STATE _____
NAME OF DIRECTOR (Last, First, Middle Initial) Jane Doe, RN		Laboratory Director's Phone Number (229) 888-8888	
CREDENTIALS Registered Nurse		FOR OFFICE USE ONLY Date Received	

II. TYPE OF CERTIFICATE REQUESTED (Check only one) Please refer to the accompanying instructions for inspection and certificate testing requirements)

Certificate of Waiver (Complete Sections I – VI and IX – X)

NOTE: Laboratory directors performing non-waived testing (including PPM) must meet specific education, training and experience under subpart M of the CLIA regulations. Proof of these qualifications for the laboratory director must be submitted with this application.

Certificate for Provider Performed Microscopy Procedures (PPM) (Complete Sections I-VII and IX-X)

Certificate of Compliance (Complete Sections I – X)

Certificate of Accreditation (Complete Sections I – X) and indicate which of the following organization(s) your laboratory is accredited by for CLIA purposes, or for which you have applied for accreditation for CLIA purposes.

- | | | | |
|---|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> The Joint Commission | <input type="checkbox"/> ACHC | <input type="checkbox"/> AABB | <input type="checkbox"/> A2LA |
| <input type="checkbox"/> CAP | <input type="checkbox"/> COLA | <input type="checkbox"/> ASHI | |

If you are applying for a Certificate of Accreditation, you must provide evidence of accreditation for your laboratory by an approved accreditation organization as listed above for CLIA purposes or evidence of application for such accreditation within 11 months after receipt of your Certificate of Registration.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0581. Expiration Date: 03/31/2024. The time required to complete this information collection is estimated to average one hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. *****CMS Disclaimer*****Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact LabExcellence@cms.hhs.gov.

III. TYPE OF LABORATORY (Check the one most descriptive of facility type)

- | | | |
|--|---|--|
| <input type="checkbox"/> 01 Ambulance | <input type="checkbox"/> 11 Health Main. Organization | <input type="checkbox"/> 22 Practitioner Other (Specify) |
| <input type="checkbox"/> 02 Ambulatory Surgery Center | <input type="checkbox"/> 12 Home Health Agency | <input type="checkbox"/> 23 Prison |
| <input type="checkbox"/> 03 Ancillary Testing Site in Health Care Facility | <input type="checkbox"/> 13 Hospice | <input type="checkbox"/> 24 Public Health Laboratories |
| <input type="checkbox"/> 04 Assisted Living Facility | <input type="checkbox"/> 14 Hospital | <input type="checkbox"/> 25 Rural Health Clinic |
| <input type="checkbox"/> 05 Blood Bank | <input type="checkbox"/> 15 Independent | <input checked="" type="checkbox"/> 26 School/Student Health Service |
| <input type="checkbox"/> 06 Community Clinic | <input type="checkbox"/> 16 Industrial | <input type="checkbox"/> 27 Skilled Nursing Facility/ Nursing Facility |
| <input type="checkbox"/> 07 Comp. Outpatient Rehab Facility | <input type="checkbox"/> 17 Insurance | <input type="checkbox"/> 28 Tissue Bank/Repositories |
| <input type="checkbox"/> 08 End Stage Renal Disease Dialysis Facility | <input type="checkbox"/> 18 Intermediate Care Facilities for Individuals with Intellectual Disabilities | <input type="checkbox"/> 29 Other (Specify) |
| <input type="checkbox"/> 09 Federally Qualified Health Center | <input type="checkbox"/> 19 Mobile Laboratory | |
| <input type="checkbox"/> 10 Health Fair | <input type="checkbox"/> 20 Pharmacy | |
| | <input type="checkbox"/> 21 Physician Office | |

IV. HOURS OF LABORATORY TESTING (List times during which laboratory testing is performed in HH:MM format) If testing 24/7 Check Here

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:		07:00	07:00	07:00	07:00	07:00	
TO:		04:00	04:00	04:00	04:00	04:00	

(For multiple sites, attach the additional information using the same format.)

V. MULTIPLE SITES (must meet one of the regulatory exceptions to apply for this provision in 1-3 below)

Are you applying for a single site CLIA certificate to cover multiple testing locations?

- No. If no, go to section VI. Yes. If yes, complete remainder of this section.

By selecting Yes, your CLIA will be used for all schools in your county/district

Indicate which of the following regulatory exceptions applies to your facility's operation.

- Is this a laboratory that is not at a fixed location, that is, a laboratory that moves from testing site to testing site, such as mobile unit providing laboratory testing, health screening fairs, or other temporary testing locations, and may be covered under the certificate of the designated primary site or home base, using its address?
 Yes No
 If yes and a mobile unit is providing the laboratory testing, record the vehicle identification number(s) (VINs) and attach to the application.
- Is this a not-for-profit or Federal, State or local government laboratory engaged in limited (not more than a combination of 15 moderate complexity or waived tests per certificate) public health testing and filing for a single certificate for multiple sites?
 Yes No
 If yes, provide the number of sites under the certificate _____ and list name, address and test performed for each site below.
- Is this a hospital with several laboratories located at contiguous buildings on the same campus within the same physical location or street address and under common direction that is filing for a single certificate for these locations?
 Yes No
 If yes, provide the number of sites under this certificate _____ and list name or department, location within hospital and specialty/subspecialty areas performed at each site below.
 If additional space is needed, check here and attach the additional information using the same format.

NAME AND ADDRESS/LOCATION	TESTS PERFORMED/SPECIALTY/SUBSPECIALTY
NAME OF LABORATORY OR HOSPITAL DEPARTMENT	
ADDRESS/LOCATION (Number, Street, Location if applicable)	
CITY, STATE, ZIP CODE	TELEPHONE NO. (Include area code)
NAME OF LABORATORY OR HOSPITAL DEPARTMENT	
ADDRESS/LOCATION (Number, Street, Location if applicable)	
CITY, STATE, ZIP CODE	TELEPHONE NO. (Include area code)

In the next three sections, indicate testing performed and estimated annual test volume.

VI. WAIVED TESTING *If only applying for a Certificate of Waiver, complete this section and skip sections VII (PPM Testing) and VIII (Non-Waived Testing).*

Identify the waived testing (to be) performed by completing the table below. Include each analyte, test system, or device used in the laboratory.

ANALYTE / TEST	TEST NAME	MANUFACTURER
Example: Streptococcus group A	Ace Rapid Strep Test	Acme Corporation
Streptococcus Group A	Consult Strep A Test Dipsticks	McKesson
Influenza A & B	Consult Influenza A&B	McKesson
Coronavirus/SARS 2	QuickVue SARS Antigen	Quidel

You may list additional tests here if applicable

Indicate the ESTIMATED TOTAL ANNUAL TEST volume for all waived tests performed

Check if no waived tests are performed

If additional space is needed, check here and attach additional information using the same format.

VII. PPM TESTING *If only applying for a Certificate for PPM, complete this section and skip section VIII (Non-Waived Testing).*

Listed below are the only PPM tests that can be performed by a facility having a Certificate for PPM. Mark the checkbox by each PPM procedure(s) to be performed.

- Direct wet mount preparations for the presence or absence of bacteria, fungi, parasites, and human cellular elements
- Potassium hydroxide (KOH) preparations
- Pinworm examinations
- Fern tests
- Post-coital direct, qualitative examinations of vaginal or cervical mucous
- Urine sediment examinations
- Nasal smears for granulocytes
- Fecal leukocyte examinations
- Qualitative semen analysis (limited to the presence or absence of sperm and detection of motility)

Indicate the ESTIMATED TOTAL ANNUAL TEST volume for all PPM tests performed

If also performing waived complexity tests, complete Section VI. For laboratories applying for certificate of compliance or certificate of accreditation, also include PPM test volume in the specialty/subspecialty category and the "total estimated annual test volume" in section VIII.

Check if no PPM tests are performed

If additional space is needed, check here and attach additional information using the same format.

VIII. NON-WAIVED TESTING (Including PPM testing if applying for a Certificate of Compliance or Certificate of Accreditation) Complete this section only if you are applying for a Certificate of Compliance or a Certificate of Accreditation.

Identify the non-waived testing (to be) performed by completing the table below. Be as specific as possible. This includes each analyte test system or device used in the laboratory. Use (M) for moderate complexity and (H) for high complexity.

ANALYTE / TEST	TEST NAME	MANUFACTURER	M or H
Example: Potassium	Quick Potassium Test	Acme Lab Corporation	M

If additional space is needed, check here and attach additional information using the same format.

If you perform testing other than or in addition to waived tests, complete the information below. If applying for one certificate for multiple sites, the total volume should include testing for ALL sites.

If additional space is needed, check here and attach additional information using the same format." Include text box similar to Section VII.

Place a check (✓) in the box preceding each specialty/subspecialty in which the laboratory performs testing. Enter the estimated annual test volume for each specialty. Do not include testing not subject to CLIA, waived tests, or tests run for quality control, calculations, quality assurance or proficiency testing when calculating test volume. (For additional guidance on counting test volume, see the instructions included with the application package.)

If applying for a Certificate of Accreditation, indicate the name of the Accreditation Organization beside the applicable specialty/subspecialty for which you are accredited for CLIA compliance. (The Joint Commission, ACHC, AABB, A2LA ,CAP, COLA or ASHI)

SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME	SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME
HISTOCOMPATIBILITY 010			HEMATOLOGY 400		
<input type="checkbox"/> Transplant			<input type="checkbox"/> Hematology		
<input type="checkbox"/> Nontransplant			IMMUNOHEMATOLOGY		
MICROBIOLOGY			<input type="checkbox"/> ABO Group & Rh Group 510		
<input type="checkbox"/> Bacteriology 110			<input type="checkbox"/> Antibody Detection (transfusion) 520		
<input type="checkbox"/> Mycobacteriology 115			<input type="checkbox"/> Antibody Detection (nontransfusion) 530		
<input type="checkbox"/> Mycology 120			<input type="checkbox"/> Antibody Identification 540		
<input type="checkbox"/> Parasitology 130			<input type="checkbox"/> Compatibility Testing 550		
<input type="checkbox"/> Virology 140			PATHOLOGY		
DIAGNOSTIC IMMUNOLOGY			<input type="checkbox"/> Histopathology 610		
<input type="checkbox"/> Syphilis Serology 210			<input type="checkbox"/> Oral Pathology 620		
<input type="checkbox"/> General Immunology 220			<input type="checkbox"/> Cytology 630		
CHEMISTRY			RADIOBIOASSAY 800		
<input type="checkbox"/> Routine 310			<input type="checkbox"/> Radiobioassay		
<input type="checkbox"/> Urinalysis 320			CLINICAL CYTOGENETICS 900		
<input type="checkbox"/> Endocrinology 330			<input type="checkbox"/> Clinical Cytogenetics		
<input type="checkbox"/> Toxicology 340			TOTAL ESTIMATED ANNUAL TEST VOLUME:		

IX. TYPE OF CONTROL (CHECK THE ONE MOST DESCRIPTIVE OF OWNERSHIP TYPE)

VOLUNTARY NONPROFIT

- 01 Religious Affiliation
- 02 Private Nonprofit
- 03 Other Nonprofit

(Specify)

FOR PROFIT

- 04 Proprietary

GOVERNMENT

- 05 City
- 06 County
- 07 State
- 08 Federal
- 09 Other Government

(If 09 is selected, please specify the country or the province.)

Does this facility have partial or full ownership by a foreign entity or foreign government?

- Yes
- No

If Yes, what is the country of origin for the foreign entity?

X. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

If the director of this laboratory serves as director for additional laboratories that are separately certified, please complete the following:

CLIA NUMBER	NAME OF LABORATORY

Fill this out if it applies to your director

ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION

Any person who intentionally violates any requirement of section 353 of the Public Health Service Act as amended or any regulation promulgated thereunder shall be imprisoned for not more than 1 year or fined under title 18, United States Code or both, except that if the conviction is for a second or subsequent violation of such a requirement such person shall be imprisoned for not more than 3 years or fined in accordance with title 18, United States Code or both.

Consent: The applicant hereby agrees that such laboratory identified herein will be operated in accordance with applicable standards found necessary by the Secretary of Health and Human Services to carry out the purposes of section 353 of the Public Health Service Act as amended. The applicant further agrees to permit the Secretary, or any Federal officer or employee duly designated by the Secretary, to inspect the laboratory and its operations and its pertinent records at any reasonable time and to furnish any requested information or materials necessary to determine the laboratory's eligibility or continued eligibility for its certificate or continued compliance with CLIA requirements.

PRINT NAME OF DIRECTOR OF LABORATORY

Jane Doe, RN

PRINT NAME OF OWNER OF LABORATORY

John Doe

SIGNATURE OF OWNER/DIRECTOR OF LABORATORY (SIGN IN INK OR USE A SECURE ELECTRONIC SIGNATURE)

DATE

10/05/2022

NOTE: Completed 116 applications must be sent to your local State Agency. Do not send any payment with your completed 116 application.

STATE AGENCY CONTACT INFORMATION CAN BE FOUND AT:

<https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>