

NEW YORK STATE DEPARTMENT OF HEALTH

Wadsworth Center

Clinical Laboratory Evaluation Program

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E-mail: CLEPLtd@health.ny.govWeb: www.wadsworth.org/regulatory/clep/limited-service-lab-certs**LIMITED SERVICE
LABORATORY REGISTRATION
Notification of Change in
Laboratory Name****LABORATORY INFORMATION:**

Laboratory PFI Number:

Effective Date of Change:

Laboratory Name:

Laboratory Street Address:

City:

State:

ZIP Code:

NEW LABORATORY NAME (Limited to 70 Characters):**CERTIFICATION:** By signing this form, I hereby certify that the information given is true and correct. **NOTE: All signatures must be original. SIGNATURE STAMPS WILL NOT BE ACCEPTED.**_____
Date_____
Signature, Laboratory Director_____
Name, Laboratory Director (Print)_____
Date_____
Signature, Owner/Representative_____
Name, Owner/Representative (Print)