

# CLINICAL LABORATORY PERMIT APPLICATION

NEW YORK STATE DEPARTMENT OF HEALTH  
Clinical Laboratory Evaluation Program  
Wadsworth Center  
Empire State Plaza  
Albany, NY 12237

E-mail: [CLEP@health.ny.gov](mailto:CLEP@health.ny.gov)  
Web: [www.wadsworth.org/regulatory/clep](http://www.wadsworth.org/regulatory/clep)

FOR OFFICE USE ONLY

Rec'd: \_\_\_\_\_

Fee No: \_\_\_\_\_

PFI: \_\_\_\_\_

CLIA No: \_\_\_\_\_

*Please review all application materials for completeness prior to submission. Incomplete or incorrect applications, or failure to submit all required forms and application fees will result in delayed processing. For a detailed description of the application process and program requirements, refer to the CLEP Program Guide, particularly the section titled "Application Procedures." Our program guide is available on our website at <http://www.wadsworth.org/regulatory/clep/clinical-labs>.*

*Section 575 of Article 5, Title V (Laboratory Services) of the Public Health Law requires that the initial application for a permit shall be accompanied by an application fee of \$100.00. This fee is not refundable.*

*Subpart 58-3 of Title 10 of the New York Codes, Rules and Regulations requires collection of a first year accreditation fee of \$1,000. This fee is in addition to the application fee.*

*The completed application should be returned, **together with the required fees of \$1,100.00**, to the appropriate address below. Checks should be made payable to the New York State Department of Health.*

## **Regular Mail**

CLINICAL LABORATORY EVALUATION PROGRAM  
WADSWORTH CENTER  
NEW YORK STATE DEPARTMENT OF HEALTH  
EMPIRE STATE PLAZA  
ALBANY, NEW YORK 12237

## **Courier Mail Address**

CLINICAL LABORATORY EVALUATION PROGRAM  
NEW YORK STATE DEPARTMENT OF HEALTH  
EMPIRE STATE PLAZA  
P1 SOUTH, LOADING DOCK J  
ALBANY, NEW YORK 12237

## **ATTACHMENTS TO THE APPLICATION**

**Required for all applications:**

**Check in the amount of \$1,100.00 payable to the New York State Department of Health  
Completed Disclosure of Ownership Interest, Controlling Interest, and Corporate Membership  
Statement, available on our website**

**Other Attachments as Applicable:**

**Copy of Management Contract  
Limited Service Laboratory Registration Application  
Copy of New York State Department of Health Article 28 Operating Certificate**

**GENERAL LABORATORY INFORMATION**

Name of Laboratory: (70 character limit)

Address: (Number and Street)

City, Town or Village:

State:

Zip Code:

County:

Telephone Number:

Fax Number:

Email Address:

Testing Hours: (Please clarify hours as AM or PM)

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
From:							
To:							

CLIA Number:

Approved

Pending

Requested (New York State Laboratories Only)

***If you currently operate a Limited Service Laboratory (LSL) at the applying location, please provide your LSL's CLIA number above.***

**To be completed by laboratories holding a NYS Medicaid Provider ID Number for New York State ONLY:**

NYS Medicaid Number:

Approved

Pending

Not Requested

**LABORATORY POINT OF CONTACT**

***It is in the best interest of the laboratory to include a contact person other than the laboratory director.***

Contact Person Name: (first name, last name)

Contact Person Telephone Number:

Contact Person Email:



**LABORATORY DIRECTORSHIP**

***There must be a doctoral-level individual named as the laboratory director. The laboratory director must hold a New York State Certificate of Qualification (CQ) in all categories for which they indicate responsibility on pages 6 & 7 of this application. If the proposed laboratory director does not already hold a CQ in one or all proposed categories of testing, the CQ application can be found on our website at : <https://www.wadsworth.org/regulatory/clip/certificate-requirements>. Submitting your CQ application at the same time as your Clinical Laboratory Permit application, can delay the Clinical Laboratory Permit application process by eight to twelve weeks.***

CQ Code:	Last 4 digits of Social Security Number:
If you do not have a CQ, have you applied?    Yes    No	

Degree(s) Held:    M.D.    D.O.    D.D.S.    D.V.M.    Ph.D.    Sc.D.

Director's First Name:	Middle Initial:	Last Name:
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Home Address: (Number and Street)

City, Town or Village:	State:	Zip Code:
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Laboratory Director Email:

***Please enter the average number of hours and frequency of your on-site presence at the laboratory. We assume that the laboratory director may be remotely accessible to the laboratory 24/7. Therefore, do not include remote access hours in the reported hours of on-site presence.***

***If on-site presence is less frequent than every other week, please choose "Other" and describe your schedule in the Hours Note field below. Note that all reported hours are subject to review and approval by the Department.***

Hours                      Weekly                      Every Other Week                      Other

Hours Note:

**OTHER EMPLOYMENT OF THE DIRECTOR**

***If the director of this laboratory serves as director for additional laboratories, please provide the following information.***

PFI	CLIA Number	Name of Laboratory

**ASSISTANT DIRECTORS**

**Excluding the director, list personnel serving the laboratory as assistant directors who hold or can qualify for Certificate(s) of Qualification and who will be designated to assume responsibility for tests performed. Note that the responsibilities of assistant directors must be specified in writing.**

**\*A person should not be designated as an assistant director if they do not hold responsibility for a category indicated on pages 6 & 7.**

CQ Code:		Last 4 digits of Social Security Number:	
If you do not have a CQ, have you applied?    Yes    No			
Degree(s) Held:    M.D.    D.O.    D.D.S.    D.V.M.    Ph.D.    Sc.D.			
Assistant Director's First Name:	Middle Initial:	Last Name:	
Home Address: (Number and Street)			
City, Town or Village:		State:	Zip Code:
Assistant Laboratory Director Email:			

**Please enter the average number of hours and frequency of your on-site presence at the laboratory. We assume that the laboratory assistant director may be remotely accessible to the laboratory 24/7. Therefore, do not include remote access hours in the reported hours of on-site presence.**

**If on-site presence is less frequent than every other week, please choose "Other" and describe your schedule in the Hours Note field below. Note that all reported hours are subject to review and approval by the Department.**

Hours Note:

**ASSISTANT DIRECTORS**

CQ Code:		Last 4 digits of Social Security Number:	
If you do not have a CQ, have you applied?    Yes    No			
Degree(s) Held:    M.D.    D.O.    D.D.S.    D.V.M.    Ph.D.    Sc.D.			
Assistant Director's First Name:	Middle Initial:	Last Name:	
Home Address: (Number and Street)			
City, Town or Village:		State:	Zip Code:
Assistant Laboratory Director Email:			

**Please enter the average number of hours and frequency of your on-site presence at the laboratory. We assume that the laboratory assistant director may be remotely accessible to the laboratory 24/7. Therefore, do not include remote access hours in the reported hours of on-site presence.**

**If on-site presence is less frequent than every other week, please choose "Other" and describe your schedule in the Hours Note field below. Note that all reported hours are subject to review and approval by the Department.**

Hours                      Weekly                      Every Other Week                      Other

Hours Note:

*Attach additional sheets if necessary.*

**CATEGORIES OR SUBCATEGORIES FOR WHICH YOU SEEK A LABORATORY PERMIT**

*A description of the permit categories offered is available on our website at: <https://www.wadsworth.org/regulatory/clep/clinical-labs/obtain-permit>. Please note the difference between categories and apply for only those categories covering the tests you intend to perform on specimens from New York.*

*Enter the CQ Code or last name for the director and assistant director(s), if any.*  
**Director      Asst. Dir      Asst. Dir**

**Check all requested Permit Categories and indicate the responsible person by checking the box under their column:**

**Andrology**

**Bacteriology**

**Blood pH and Gases**

**Blood Services**

- Collection
- Collection-Autogeneic Only
- Transfusion
- Transfusion Storage Only

**Cellular Immunology**

- Leukocyte Function
- Malignant Leukocyte Immunophenotyping
- Non-Malignant Leukocyte Immunophenotyping

**Clinical Chemistry**

**Cytogenetics**

**Cytokines**

**Cytopathology**

- Gynecological Testing
- Non-gynecological Testing

**Diagnostic Immunology**

- Diagnostic Services Serology
- Donor Services Serology

**Endocrinology**

**Fetal Defect Markers**

**Forensic Identity**

**Genetic Testing**

- Biochemistry
- Molecular

*Attach additional sheets for assistant directors if necessary.*

**CATEGORIES OR SUBCATEGORIES FOR WHICH YOU SEEK A LABORATORY PERMIT (continued)**

*Enter the CQ Code or last name for the director and assistant director(s), if any.*

**Director      Asst. Dir.      Asst. Dir**

**Check all requested Permit Categories and indicate the responsible person by checking the box under their column:**

**Hematology**

**Histocompatibility**

**Histopathology**

General

Dermatopathology

Oral Pathology

**Immunochemistry**

**Mycobacteriology**

**Mycology**

**Oncology-Molecular and Cellular Tumor Markers**

**Parasitology**

**Parentage/Identity Testing**

**Therapeutic Substance Monitoring/ Quantitative Toxicology**

**Toxicology**

Blood Lead - Comprehensive

Blood Lead - ASV Using Screen- Printed Sensors

Forensic Toxicology - Initial Testing Only

Forensic Toxicology - Comprehensive

Clinical Toxicology - Qualitative Testing

Clinical Toxicology - Comprehensive

**Trace Elements**

**Transplant Monitoring**

**Urinalysis**

**Virology**

**Wet Mounts**

*Attach additional sheets for assistant directors if necessary.*

CERTIFICATION		
<b>I HAVE REVIEWED COPIES OF THE FOLLOWING DOCUMENTS available on our "Laws &amp; Regulations" website at <a href="http://www.wadsworth.org/regulatory/clep/laws">www.wadsworth.org/regulatory/clep/laws</a>:</b>		
<b>Public Health Law:</b> Title I - Communicable Disease, Laboratory Reports and Records Article 5, Title V of the Public Health Law - Clinical Laboratory and Blood Banking Services Article 5, Title VI of the Public Health Law - Laboratory Business Practices Article 2, Title II-D of the Public Health Law - Health Care Practitioner Referrals Article 27-F, of the Public Health Law - HIV and AIDS Related Information Civil Rights Law, Section 79-I - Confidentiality of Records of Genetics Tests	<b>YES</b> <b>NO</b>	
<b><u>New York Code of Rules and Regulations (10 NYCRR):</u></b> Part 2 - Communicable Diseases Part 19 - Duties and Qualifications of Clinical Laboratory Directors Part 22 - Environmental Diseases Subpart 34 - Health Care Practitioner Referrals Subpart 58-1 - Clinical Laboratories Subpart 58-2 - Blood Banks Subpart 58-3 - Clinical Laboratory Inspection and Reference Fees Subpart 58-8 - Human Immunodeficiency Virus (HIV) Testing Part 63 - AIDS Testing and The Confidentiality of HIV-Related Information Part 67 - Reporting of Blood Lead Levels Part 70 - Regulated Medical Waste		
<b><u>Laboratory Standards</u></b> , available at: <a href="https://www.wadsworth.org/regulatory/clep/clinical-labs/laboratory-standards">https://www.wadsworth.org/regulatory/clep/clinical-labs/laboratory-standards</a>		
<p>In signing this application, I hereby certify that the information I have given the Department of Health as a basis for obtaining a laboratory permit is true and correct.</p> <p>I understand that the permit of this laboratory may be revoked, suspended, limited, or annulled if any fact is misrepresented in this application. I acknowledge that that Public Health Law stipulates that a laboratory permit is automatically void upon a change of director, owner or location. <b>Changes in any of the information in this application must be reported to the Clinical Laboratory Evaluation Program immediately by the laboratory director or owner.</b> I also understand that additional penalties may apply if I misrepresent, conceal, or fail to disclose facts or information regarding my initial and continuing eligibility for said laboratory permit.</p> <p>I understand that by signing this application form I agree to any investigation made by the Department of Health to verify or confirm the information I have given or any other investigation in connection with my laboratory permit, or a complaint received by the Department. If additional information is requested, it will be provided in a timely manner by the appropriate staff under the direction of the laboratory director and owner. Further, I understand that, should this application or my status be investigated at any time, I agree to cooperate in such an investigation.</p> <p>Finally, I understand that all records pertaining to the laboratory in the department's possession will be subject to disclosure to the federal CLIA program and, if I am operating a laboratory located in New York State, the laboratory is subject to validation inspections conducted by federal CLIA program staff and will allow entry of those staff for such purposes.</p>		

Print Name of Director	Signature of Director	Date
Print Name of Owner	Signature of Owner/Representative	Date
Print Name of Assistant Director	Signature of Assistant Director	Date
Print Name of Assistant Director	Signature of Assistant Director	Date