**DEPARTMENT OF PUBLIC HEALTH**

**CLINICAL LABORATORY PROGRAM**

67 Forest Street, Marlborough, MA 01752

(617) 753-8438 fax (617) 753-8240

I. APPLICATION INFORMATION

|  |  |
| --- | --- |
| Name: |  |

|  |  |
| --- | --- |
| Address: |  |

 Street City State Zip code

|  |  |  |  |
| --- | --- | --- | --- |
| Telephone: |   | Contact Person: |  |
|  | EMAIL: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| CLIA #: |  | Certificate Type: |  |

II. SCREENING PROGRAM INFORMATION

A.) Location type (check all that apply)

 [ ]  Permanent/Fixed (complete section III) [ ]  Temporary/Mobile (complete section IV)

B.) Facility or company which will provide final disposal of the holder’s special medical waste:

|  |  |
| --- | --- |
| Name: |  |

|  |  |
| --- | --- |
| Address: |  |

 Street City State Zip code

|  |  |
| --- | --- |
| Telephone: |  |

C.) Licensed laboratory where specimens will be sent semi-annually to verify test accuracy:

|  |  |
| --- | --- |
| Name: |  |

|  |  |
| --- | --- |
| Address: |  |

 Street City State Zip code

|  |  |  |  |
| --- | --- | --- | --- |
| Telephone: |  | Contact Person: |  |

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III. PERMANENT/FIXED SCREENING PROGRAM

A.) Location (address) of Screening Program B.) Schedule of Operation

 Days of Week Time (Hours)

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

C.) Test procedure (check all that apply)

|  |  |
| --- | --- |
| Test | Method/analyzer |
| [ ]  cholesterol [Capillary Whole Blood] |  |
| [ ]  erythrocyte protoporphyrin [Capillary Whole Blood] |  |
| [ ]  fecal occult blood |  |
| [ ]  hemoglobin [Capillary Whole Blood] |  |
| [ ]  hematocrit [Capillary Whole Blood] |  |
| [ ]  hdl cholesterol [Capillary Whole Blood] |  |
| [ ]  glucose [Capillary Whole Blood] |  |
| [ ]  pregnancy test, qualitative |  |

D.) Briefly state the purpose for offering the test(s) checked above.

|  |
| --- |
|  |
|  |
|  |
|  |
| Signature of Authorized Individual |  |
| Title: |  |
| Date: |  |
| Telephone: |  |

IV. temporary/mobile screening program

Please complete a separate application for each site where the screening program is offered and return to the above address at least 5 days prior to each screening event. PLEASE MAKE COPIES AS NECESSARY.

|  |  |
| --- | --- |
| applicant name: |  |

A.) Location (address) of Screening Program B.) Schedule of Operation

 Days of Week Time (Hours)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

C.) Test procedure (check all that apply)

|  |  |
| --- | --- |
| Test | Method/analyzer |
| [ ]  cholesterol [Capillary Whole Blood] |  |
| [ ]  erythrocyte protoporphyrin [Capillary Whole Blood] |  |
| [ ]  fecal occult blood |  |
| [ ]  hemoglobin [Capillary Whole Blood] |  |
| [ ]  hematocrit [Capillary Whole Blood] |  |
| [ ]  hdl cholesterol [Capillary Whole Blood] |  |
| [ ]  glucose [Capillary Whole Blood] |  |
| [ ]  pregnancy test, qualitative |  |

D.) Briefly state the purpose for offering the test(s) checked above.

|  |
| --- |
|  |
|  |
|  |
|  |
| Signature of Authorized Individual |  |
| Title: |  |
| Date: |  |
| Telephone: |  |

The Health Promotion Screening application packet must contain all of the following documents/forms.

[ ]  Health Screening Promotion application – completed and signed

[ ]  CLIA application – completed and signed [if the facility does not already have a current certificate]

[ ]  Procedure for performing test(s) [see item 1]

[ ]  Calibration procedure and documentation form [see items 2 and 5]

[ ]  Quality control procedure and documentation form [see items 4 and 5]

[ ]  Patient test report form and educational materials [see item 6]

[ ]  Training records [see item 8]