APPLICATION-- CLINICAL LABORATORY REGISTRATION
Refer to California Business and Professions Code, Division 2, Chapter 3

Instructions: Use typewriter or print in ink. Complete both pages of this application and return with required information and fee to:
California Department of Public Health
Laboratory Field Services /ATT: Clinical Laboratory Registration
850 Marina Bay Parkway, Bldg. P, 1st Floor
Richmond, CA 94804-6403

For application questions, e-mail: LFSRecep@cdph.ca.gov

Make checks payable to: California Department of Public Health
Items 1-3 MUST agree with the information for the CLIA Provider number and on the application for a Medi-Cal Provider number.

1. Name of laboratory
Address (number, street) City County State ZIP code (include +4 digits)

Telephone number Fax number E-mail address
( ) ( )

2. CLIA provider number
O5D ___ ___ ___ ___ ___ ___ ___ ___

3. Type of certificate
☐ Certificate of Waiver ☐ Provider Performed Microscopic Procedure

4. Legal name of corporation, district, or association owning laboratory (fictitious name permit must be on file—state the name of locality where permit is filed)

5. Type of ownership. Check (✓) and complete name and personal address (Section 1211 of Business and Professions Code).

☐ Individual
Name
Personal address (number, street) City State ZIP code

☐ Partnership (general or limited). List name(s) and address(es) of all members of the partnership. Use supplementary sheet if necessary.

Name
Personal address (number, street) City State ZIP code

Name
Personal address (number, street) City State ZIP code

Name
Personal address (number, street) City State ZIP code

☐ Corporation. State names of officers, directors, shareholders holding a 5% or more 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.)

Name
Personal address (number, street) City State ZIP code

Name
Personal address (number, street) City State ZIP code

Name
Personal address (number, street) City State ZIP code

Name
Personal address (number, street) City State ZIP code

☐ Unincorporated association

Name
Personal address (number, street) City State ZIP code
☐ District, city, county, or state

Name | Personal address (number, street) | City | State | ZIP code

☐ Other (specify) (if nonprofit, submit proof of nonprofit status):

Name | Personal address (number, street) | City | State | ZIP code

6. Laboratory Director(s) (M.D., D.O.)

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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 (M.D., D.O.)  Type or print name  Title  Date

Owner signature  Type or print name  Title  Date