Laboratory Licensing Change Form

This form is for changes and updates between licensing cycles, it cannot be used to renew your license. Please provide us with the changes in the fields below along with the effective date of the change.

For a change of Director, a copy of the Director's medical license, medical diploma and board certification must be submitted. Please send diploma, board certification and CV for a PhD Director. CLIA certificate of compliance and PPM labs must submit a CLIA 116 application as well to update director.

CLIA certificate of accreditation labs must contact their accreditation agency to update director.

***THIS FORM MUST BE SIGNED BY THE DIRECTOR FOR ALL CHANGES TO BE VALID.***

Please return this form by fax:
410-402-8213

Current Name of Lab: ____________________________

State Lab ID # _______ Federal CLIA #: _________ Is this CLIA a multisite? Y N

Laboratory Name: _______________________________ Date of Change: _________

Owner: _______________________________ Date of Change: _________

Tax ID #: _______________________________ Date of Change: _________

Director: _______________________________ Date of Change: _________

Physical Address: _______________________________ Date of Change: _________

Mailing/Billing Address: __________________________ Date of Change: _________

Telephone #: _______________________________ Date of Change: _________

Fax #: _______________________________ Date of Change: _________
Please list the tests you are adding or deleting from your current test menu. Please use the chart below and indicate for each test the instrument/kit used as well as the effective date of change.

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Kit/Instrument Used</th>
<th>Add</th>
<th>Delete</th>
<th>Date of Change</th>
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</table>

Change State License Status to:

☐ Letter of Exception  ☐ General Permit  Date of Change: ____________

Change my CLIA Certification Status to: (must submit with a CMS-116, both forms must then be mailed to our address)

☐ Waiver  ☐ Compliance  ☐ Provider Performed Microscopic Procedures (PPMP)

☐ Accreditation with which program? ______________________________

Date of Change: ____________

Our office has closed and/or discontinued all clinical testing. Date of Change: ____________

Print Laboratory Director’s Name: ________________________________

Laboratory Director’s Signature: _________________________ Date: ____________