For Office Use Only
License Number: RDT-
Date Received:

Maryland Department of Health
Office of Health Care Quality
Laboratory Licensing
Rare Disease Testing Application

A. Laboratory Information
Name of Laboratory:
CLIA Number:
Facility Street Address:
City, State, Zip Code:
Mailing Address (if different than Facility Address):
Mailing Address: City, State, Zip Code:
Business Phone:
Contact Person:
Business Fax:
Business Email:
B. Laboratory Director Information
Director Name:
Degree:
Certification By American Specialty Board (Name, Date, Number):
State Medical License:
Rare disease (see COMAR 10.10.01.03(64) for definition of "rare disease") licensure limits the licensee to perform not more than 50 rare disease tests each year on specimens received from Maryland patients (COMAR 10.10.03.06(A)(2)(c)).
Proficiency testing (if not enrolled in a commercial proficiency testing program, please describe the in-house proficiency testing program):
List rare disease testing including prevalence or incidence:

Describe quality control program:
C. Ownership Information
Owner's Name:
Owner's Address:
Federal Tax ID (EIN Number):
D. Attestation
I certify that the information provided in this application is true and complete. I agree to abide by the laws of Maryland governing medical laboratories, and I understand that any willful and knowing false statement or representation, or failure to fully disclose the requested information in this application may lead to a denial of license, or the suspension or revocation of the rare diseases testing license issued to this entity to offer or perform medical laboratory tests. I also understand that compliance with State laws and **regulations may not assure compliance with federal requirements.**
Signature of Laboratory Director:
Date: