APPLICATION FOR LICENSURE FOR MEDICAL LABORATORY

FOR ADMINISTRATIVE USE ONLY

Date received ______________________

Amount received ______________________

I. IDENTIFICATION

Name of Laboratory ______________________

Address ______________________
STREET

____
CITY COUNTY ZIP CODE

Telephone Number ____________ Email Address ____________

Director's Name ______________________

Director's Level of Education ______________________

Date the laboratory began operation at present address ____________

Date laboratory began operation under present Director ____________

II. CONTROL (Check one in each column)

State	( )	Profit	( )	Individual	( )
County	( )	Nonprofit	( )	Partnership	( )
City	( )			Corporation	( )
Private	( )				

A. If the laboratory is operated by an individual or partnership, complete the following information on the individual or partners:

Name: ______________________

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B. If the laboratory is operated by a corporation, complete the following:

Name of Corporation ______________________________

State where incorporated ______________________________

Address ______________________________

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President of Chairman ______________________________

Vice President ______________________________

Treasurer ______________________________

C. If the laboratory is owned by other than the persons listed in A or B above, complete the following:

Name of Owner ______________________________

Address of Owner ______________________________

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III. **SERVICES** (Check applicable services)

	HISTOCOMPATIBILITY
( )	Transplant
( )	Nontransplant
	MICROBIOLOGY
( )	Bacteriology
( )	Mycobacteriology
( )	Mycology
( )	Parasitology
( )	Virology
	DIAGNOSTIC IMMUNOLOGY
( )	Syphilis Serology
( )	General Immunology
	CHEMISTRY
( )	Routine
( )	Urinalysis
( )	Endocrinology
( )	Toxicology

	HEMATOLOGY
( )	Hematology
	IMMUNOHEMATOLOGY
( )	ABO Group & Rh Group
( )	Antibody Detection (trans)
( )	Antibody Detection (nontrans)
( )	Antibody Detection
( )	Compatibility Testing
	PATHOLOGY
( )	Histopathology
( )	Oral Pathology
( )	Cytology
	RADIOBIOASSAY
( )	Radiobioassay
	CLINICAL CYTOGENETICS
( )	Clinical Cytogenetics
	OTHER
( )	
( )	

I understand that any change in laboratory services that affects my licensure will be reported to the Office of the Inspector General and a new application will be completed at that time. I agree that this laboratory and all apsects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

______________________ ____

Date Signature of Authorized Representative

Licensure Fee Per Laboratory:	Initial	$155.00
	Renewal	$80.00

Make check or money order payable to: Kentucky State Treasurer. **Please do not send cash**

Please return completed form to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621