LABORATORY REGISTRATION OR LICENSURE APPLICATION

NEVADA STATE HEALTH DIVISION
Bureau of Health Care Quality and Compliance
727 Fairview Drive, Suite E
Carson City, Nevada 89701
Phone: (775) 684-1030 Fax: (775) 684-1075
http://www.health.nv.gov/HCQC_Medical.htm

This application must be accompanied by a check for the appropriate amount made payable to the Nevada State Treasurer. Under Nevada Administrative Code (NAC) 652.488 the fee is non-refundable. Insufficient funds charge: $25.00 per NAC 353C.400. Regulations may be viewed at http://leg.state.nv.us.

Current State Lab Number: ____________________

This application is for:

Licensed Lab (Services to General Public)
Fees are based on test volume:
- ☐ Less than 25,000 = $1,100.00
- ☐ 25,000 and less than 100,000 = $3,000.00
- ☐ 100,000 or more = $4,000.00

☐ **Registered Lab (Private Practice)**
Fee $1,500.00
- ☐ Reactivation (Same fee as initial)
- ☐ Ownership (Same fee as initial)

Changes to an existing lab (check all that apply):

	Existing	New
☐ Add Tests		
☐ Director		
☐ Location		
☐ Name		

The fee for making any changes to the director, location, name or test addition of the lab is $300.00, plus $50.00 for each additional specialty.

Laboratory/Business Name	Doing Business As (DBA)
Phone Number (starting with the area code)	Fax Number (starting with the area code)
Street Address	Mailing Address (if different from street address)
City	City
County	County
State	State
Zip Code	Zip Code
Director	General Supervisor
Hours of Operation	**Contact Person and Phone Number**
CLIA Type (or attach application HCFA 116)	**CLIA Number**

Ownership Information:
List names and addresses of all individuals or organizations having direct or indirect ownership or control of 10% or more in the lab NRS 652.090. Please attach a complete listing if additional space is needed.

Name	Address

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TESTS PERFORMED IN THE LABORATORY

☐ Histocompatibility
☐ Transplant
☐ Nontransplant

☐ Microbiology
☐ Bacteriology
☐ Mycobacteriology
☐ Mycology
☐ Parasitology
☐ Virology
☐ Other

☐ Diagnostic Immunology
☐ Syphilis Serology
☐ General Immunology

☐ Chemistry
☐ Routine
☐ Urinalysis
☐ Endocrinology
☐ Toxicology
☐ Other

☐ Hematology

☐ Immunohematology
☐ ABO Group & Rh Type
☐ Antibody Detection (transfusion)
☐ Antibody Detection (nontransfusion)
☐ Antibody Identification
☐ Compatibility Testing
☐ Other

☐ Pathology
☐ Histopathology
☐ Oral Pathology
☐ Cytology

☐ Radiobioassay

☐ Clinical Cytogenetics

Laboratory Type:
☐ Private ☐ Non-profit
☐ Government ☐ Corporation (List Corporate Directors' name(s) and addresses)

List all modules of Proficiency Testing program enrollment:

____

List name, address and phone number of individual(s) responsible for records in the event the laboratory closes:

Name	Address	Phone Number

Required Documents:

1. **Copy of all current physicians' licenses (wallet size is acceptable) – Per NAC 652.470**
2. **Attach a list of personnel performing test and/or collecting specimens – Per NRS 652.210**

DIRECTOR'S SIGNATURE MUST BE NOTARIZED

I attest that the laboratory is in continued compliance with CDC's safe injection practices. I have read understood and agree to comply with the rules and regulations pertaining to the specific type of facility for which licensure applications are herein made.

Lab Physician/Director's Signature ______________________________

Please PRINT and SIGN Name
Must be an ORIGINAL: photocopies or signature stamps are not acceptable.

Name and Signature of Notary: ____________________ **Date:** ____________

State of: ____________________ **County of:** ____________

Subscribed and sworn before me this: ____________________ **Day of:** ____________