

**Kings County Public Health Laboratory**  
**330 Campus Drive, Hanford CA 93230 -- (559) 852-2607 Fax (559) 583-8178**

Complete this form for initial registration of a program. This registration form must be completed and received by at least 30 days prior to operating a program of nondiagnostic general health assessment. Complete a "Site Registration" form for each site where testing is to be performed.

**PART 1: ADMINISTRATION:****A. NAME OF ORGANIZATION OR OPERATOR:** \_\_\_\_\_

Address: \_\_\_\_\_

Zip code: \_\_\_\_\_

Business phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email: \_\_\_\_\_

**B. NAME OF OWNER:** \_\_\_\_\_

Address: \_\_\_\_\_

Zip code: \_\_\_\_\_

Business phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**C. SUPERVISORY COMMITTEE MEMBERSHIP: (PROVIDE COPIES OF LICENSES/CERTIFICATES)**

Name of physician: \_\_\_\_\_

Address: \_\_\_\_\_

Zip code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

California medical license number: \_\_\_\_\_ Exp. date \_\_\_\_\_

Name of laboratory technologist: \_\_\_\_\_

Address: \_\_\_\_\_

Zip code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

California clinical laboratory technologist license # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**D. CLIA IDENTIFICATION NUMBER: (PROVIDE COPY OF CERTIFICATE)** \_\_\_\_\_ Exp Date: \_\_\_\_\_

**PART 2: ASSESSMENT PROGRAM**

- A. TESTING PROGRAM:  **Single site** (one location only)  
 **Multiple sites** (mobile locations)

**B. TYPE OR KIND OF NONDIAGNOSTIC HEALTH ASSESSMENTS BEING CONDUCTED.**

- ( ) Total cholesterol                      ( ) High-density lipoproteins (HDL)                      ( ) Low-density lipoproteins (LDL)  
( ) Triglycerides                              ( ) Blood Glucose                                              ( ) Occult blood

Other, specify: \_\_\_\_\_

**C. TYPE AND MANUFACTURER OF TESTING EQUIPMENT TO BE USED.**

Name of Equipment	Manufacturer
_____	_____
_____	_____
_____	_____
_____	_____

**D. TYPE & MANUFACTURER OF FINGER STICK LANCET: (Please attach blood collection & medical waste procedures)**

- Disposable**                                               **Multiple Use**

**PART 3:**

Name of person requesting registration: \_\_\_\_\_  
Address if different than above: \_\_\_\_\_  
Zip code: \_\_\_\_\_  
Business phone: (     ) \_\_\_\_\_ Fax: (     ) \_\_\_\_\_

I certify that the above information is accurate and complete and that I am aware of the laws and regulations that apply to nondiagnostic testing in the State of California and in the County in which testing is to be performed.

\_\_\_\_\_  
**Signature of Applicant**                                              **Date of application**

**FOR OFFICIAL USE ONLY**

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Registration number:** \_\_\_\_\_ **Date issued:** \_\_\_\_\_  
**Expiration Date:** \_\_\_\_\_