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: _____

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

Name of Corporation _____

State where incorporated _____

Address _____

_____

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 _____

_____

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