NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM
EMPIRE STATE PLAZA, P.O. BOX 509
ALBANY, NEW YORK 12201-0509

Telephone: (518) 485-5378 Fax: (518) 485-5414
E-mail: CLEPCERT@health.state.ny.us
Web: www.wadsworth.org/labcert/clep/clep.html

Disclosure of Ownership and Controlling Interest Statement

INSTRUCTIONS

I. GENERAL

Completion and submission of this statement to provide full and accurate disclosure of ownership and financial interests in the clinical facility is required by Section 58-1.1 of Title10, New York Code of Rules and Regulations. Failure to do so may result in the denial of a permit to a laboratory or blood bank. **Note: The completion of this statement does not eliminate the responsibility of the applicant to report all changes in ownership in the applying facility directly to the New York State Department of Health, Office of Medicaid Management, at One Commerce Plaza, Albany, NY 12260.**

II. COMPLETION OF STATEMENT

Definitions

Direct ownership interest means the possession of stock, equity in the capital, or any interest in the profits of the applying clinical facility.

Indirect ownership interest means the possession of stock, equity in the capital, or any interest in the profits of an entity with a direct or indirect ownership interest in the applying clinical facility.

Controlling interest means the ability to direct or control the operation or management of the applying clinical facility.

Management company means any organization that operates and manages a business on behalf of the owner, with the owner retaining ultimate legal responsibility for the operation of the business.

Statement Information

Part I - Identifying Information – Provide name, address, telephone number, and if the laboratory has a permit, the laboratory PFI and Code numbers of the facility.

Part II – List the names of all individual and organizations having direct, indirect, or controlling interest of five (5) percent or greater in the laboratory or blood bank. For facilities owned/operated by not-for profit corporations, please provide a list of the Board of Directors.

Part III – Respond to questions A-D.

Part IV – This form must be signed by the owner or an authorized representative (corporate officer or designee). Please provide a contact telephone number and email address, if applicable, for the individual signing this form.

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Part I – Identifying information (Please print or type)

PFI/Code number			
Name of Facility			
Address			
City	State	Zip	Telephone ( )

Part II – Ownership Information (Please print or type)

A. List names, addresses and social security numbers for individual owners, partners, corporation officers, and/or shareholders possessing 5 percent or more of the voting shares in the entity having direct or indirect ownership or controlling interest in the applying clinical facility. (See instructions for definition of ownership and controlling interest). Names and addresses may be listed on a separate sheet and attached to this statement. For laboratories owned/operated by not-for-profit corporations, please provide a list of the Board of Directors.

Name	
Address	
	Social Security Number

Name	
Address	
	Social Security Number

Name	
Address	
	Social Security Number

Name	
Address	
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Part II – Ownership Information (continued)

B. Ownership Type:

- ☐ Partnership
- ☐ Individual
- ☐ For-Profit Corporation
- ☐ Not-for-Profit Corporation
- ☐ Government
- ☐ Other (specify) _____

C. If owner name is not the same as the laboratory name, indicate owner name and address.

D. Do any of the owners of the applying facility have direct or indirect ownership or controlling interest in any other clinical laboratories licensed by New York State?

☐ Yes ☐ No

If yes, provide the information requested below for each individual on a separate sheet and attach to this form.

Owner Name Other Facility Name & Address

Part III - Declaration

Answer the following questions by checking the appropriate "Yes" or "No" box.

A. Have the director, any assistant director(s), or those having a direct or indirect ownership or controlling interest in the laboratory or blood bank had charges sustained of administrative violations of local, state or federal laws, rules and regulations, including, but not limited to, the Public Health Law or related statues, concerning the provision of health care services or reimbursement for such services against them? Are such charges currently pending?

☐ Yes ☐ No

If yes, list name and address of individuals on a separate sheet and attach to this form.

B. Have the director, any assistant director(s), or those having a direct or indirect ownership or controlling interest in the laboratory or blood bank ever been convicted of any crime, including, but not limited to any offense related to furnishing of or billing for clinical laboratory services and medical care, services or supplies, or which is considered an offense involving theft or fraud? Are such charges currently pending?

☐ Yes ☐ No

If yes, list name and address of individuals on a separate sheet and attach to this form.

C. Are any individuals, with direct or indirect ownership or controlling interest in the applicant laboratory or blood bank, licensed health professionals, authorized by law to order clinical laboratory tests and receive results?

☐ Yes ☐ No

If yes, list name and address of individuals on a separate sheet and attach to this form.

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Part III – Declaration (continued)

D. Is this facility operated by a management company, or leased in whole or part by another organization?

☐ Yes ☐ No

If yes give name and address of management company or licensee.

_____

_____

_____

Part IV -Signature

Providing false or misleading information in this statement may lead to prosecution under applicable federal or state laws, and may result in denial of the New York State Clinical Laboratory Permit application.

_____
Name of Authorized Representative (please type or print) Title

_____
Signature Date

Contact Phone Number _____ Email Address _____