

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) 402-4253 Fax: (518) 449-6902  
 E-mail: clepltd@health.state.ny.us  
 Web: http://www.wadsworth.org/labcert/limited/

**LIMITED SERVICE  
 LABORATORY REGISTRATION  
 Notification to Add and/or Delete  
 Test Procedure(s)**

**LABORATORY INFORMATION:**

Laboratory PFI Number:	Laboratory Name:		
	Street Address:		
	City:	State:	ZIP Code:

**LABORATORY TESTING INFORMATION:**

Article 5, Title V, Section 3 of the New York State Public Health Law states that Limited Service Laboratories may only provide the tests listed on the registration issued by the Department. Therefore, Limited Service Laboratories may not begin patient testing until written confirmation is received from this Program. **(\*NOTE: For laboratories wishing to offer lead, rapid HCV and/or rapid HIV testing using a kit, device or procedure, which has been designated by the Food and Drug Administration as Waived for purposes of CLIA '88, you must submit a written protocol with this form. Non-DOT breath alcohol testing must be performed using an FDA approved IVD Over-The-Counter device.)**

1.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
2.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
3.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
4.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
5.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
6.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
7.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
8.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
9.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete
10.	Test Procedure Name:		Request:	<input type="checkbox"/> Add <input type="checkbox"/> Delete

**CERTIFICATION:** By signing this form, I hereby certify that the information given is true and correct. I attest that I have reviewed a copy of the most current Limited Service Laboratory Registration application on file with the Department for this laboratory, and will comply with the requirements of Section 579 of the Public Health Law. I also assume responsibility for any laboratory testing performed at secondary testing sites covered under this CLIA Number and Limited Service Laboratory Registration. **NOTE: All signatures must be original. SIGNATURE STAMPS WILL NOT BE ACCEPTED.**

Date	Signature, Laboratory Director	Name, Laboratory Director (Print)