

**LABORATORY PERSONNEL
QUALIFICATION APPRAISAL
and
APPLICATION FOR LICENSURE**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF LABORATORY SERVICES
167 11th Avenue
South Charleston, West Virginia 25303

Name _____

Social Security Number _____ - _____ - _____

Laboratory _____

CLIA Certificate No. _____

GENERAL INSTRUCTIONS

- A. Print in ink or type all information. Avoid abbreviations, if possible. Do not abbreviate name of city or town.
- B. Complete all items that apply to you. If more space is required, specific pages may be copied.
- C. Attach check or money order, (\$25.00) to the application payable to **State of West Virginia DHHR Lab.** Do not send cash.
- D. Be sure the application is signed in places designated by applicant and laboratory director, if currently employed.
- E. Applications which are not completed or applications submitted with an incorrect fee will be returned and will not be processed.
- F. Notify Office of Laboratory Services, at the above address, of any change of address or change of name (by marriage or divorce), or any change of work status.
- G. Individuals performing only waived tests as defined in the Clinical Laboratory Improvement Amendments (CLIA) of 1988 are not required to be licensed and do not need to complete this form.
- H. Individuals providing diagnostic testing within the scope of his/her professional license who perform moderate complexity testing as defined by CLIA, such as respiratory care providers or those designated to perform provider-performed microscopy procedures, need not be licensed.

SPECIFIC INSTRUCTIONS

NOTE: **The following numbers correspond to numbered sections on the application. Read carefully before proceeding.**

- 1-2 IDENTIFICATION, MAILING AND PERSONAL DATA:
Your application may not be processed without a complete mailing address, including apartment number (if any) and zip code. Married applicants must include maiden name.
3. PRESENT EMPLOYER
Write name of the facility and give full mailing address and telephone number.
- 4-5. SELF-EXPLANATORY
6. POSITION CURRENTLY HELD
Check all that apply.
7. JOB FUNCTION CATEGORY
Check all that apply to your current status. If you rotate, check all specialties through which you will rotate. If “other”, specify function(s).
- 8 - 11. EDUCATION, TRAINING, CERTIFICATION, EXPERIENCE DATA:
Complete this part as thoroughly as possible. This office reserves the right to request documentation if deemed necessary to verify your qualifications for licensure.
12. SELF-EXPLANATORY
13. CERTIFICATION : There are several ways to be certified under 64-57-2. The two CLIA-88 qualifications apply to those performing these tests up to April 24, 1995. See attached.
14. If you do not qualify for licensure by certification, as described under 64-5-2, your laboratory director must verify that you have the training and skills necessary to perform the tests which are listed on page 7.
15. DIRECTOR'S VERIFICATION OF COMPETENCY: To be completed by applicant and laboratory director if applicant is not certified by a certifying agency listed in question 13 (ASCP, AMT, NCA, ISCLT/AAB, HEW, etc.).
16. ALL APPLICANTS must complete this part (page 6).
- 17-18. SELF-EXPLANATORY and must be completed on all applications.

LABORATORY PERSONNEL QUALIFICATION APPRAISAL and APPLICATION FOR LICENSURE

An individual employed as a clinical laboratory practitioner in a clinical laboratory in West Virginia must establish his/her qualifications under the West Virginia Division of Health Legislative Rule (64 CSR 57). Exceptions are listed under 1.6 and 1.7 of the rule. The Clinical Laboratory Technician and Technologist Licensure and Certification Program needs the following information to determine whether the individual listed in Item 1 meets the requirements for laboratory licensure. Authority to collect the information is given in 5.1 of the rule. Your response is voluntary; however failure to furnish the requested information may result in your not being licensed. If you do furnish the information, it will be used for:

- 1.) Routine administrative processes carried out in accordance with established regulations and published notices of systems of records, and
- 2.) Disclosures expressly permitted by the Privacy Act without the individual's consent, e.g., to the Bureau of the Census. The information will not be released to any persons or organizations outside of official administrative channels unless the individual specifically requests in writing that such disclosures be made. (Privacy Act of 1974 - Public Law 93-579.)

Verifications of degree, diplomas, board certification, etc., are required.

1. Name (Last, First, Middle)	3. Present Employer
2. Maiden Name if Married	Address
Mailing Address	City State Zip Code
City State Zip Code	Work Telephone () - Home Telephone () -
4. Employment Work Arrangements <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not currently employed	5. Complexity of testing:(check all that apply) <input type="checkbox"/> Waived <input type="checkbox"/> Moderate <input type="checkbox"/> High
6. Position(s) Currently Held in Laboratory <input type="checkbox"/> 01 Director (D) <input type="checkbox"/> 02 General Supervisor (GS) <input type="checkbox"/> 03 Cytotechnologist Supervisor (CTS) <input type="checkbox"/> 04 Technical Supervisor/Consultant (TS/C) <input type="checkbox"/> 05 Technologist (T) <input type="checkbox"/> 06 Cytotechnologist (CT) <input type="checkbox"/> 07 Technician (Tn) <input type="checkbox"/> 08 Point of Care Technician (POCT) <input type="checkbox"/> 09 Other (Specify)	7. Check the following in which you presently function: <input type="checkbox"/> Microbiology <input type="checkbox"/> Histocompatibility <input type="checkbox"/> Serology <input type="checkbox"/> Radioimmunoassay <input type="checkbox"/> Chemistry <input type="checkbox"/> Virology <input type="checkbox"/> Hematology <input type="checkbox"/> Toxicology <input type="checkbox"/> Immunohematology <input type="checkbox"/> Cytology <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Point of Care Testing

8. EDUCATION

8a. High School Graduate or Equivalent

Yes

No

College, University or Other School(s) Attended

8b. Name and address of Institution	From		To		Major	Degree, Diploma or Certificates	Conferred	
	Mo.	Yr.	Mo.	Yr.			Mo.	Yr.

9. CLINICAL LABORATORY TRAINING - TRAINING FULFILLING OR PARTIALLY FULFILLING A DEGREE, DIPLOMA, OR CERTIFICATE REQUIREMENT LISTED IN ITEM 10.

Name and Address	Attended				Program Title	Degree, Diploma or Certificate	Conferred	
	From		To				Mo.	Yr.
	Mo.	Yr.	Mo.	Yr.				

10. LICENSE, CERTIFICATION, OR REGISTRATION

Name of Granting Agency	Certification or Registration Title	Granted		Lic., Cert., or Reg. No.	MD/DO (✓)if only Bd. Elig.
		Mo.	Yr.		

11. CLINICAL LABORATORY EXPERIENCE

Name and Address of Laboratory or Institution Begin with earliest employment and continue through present employment. Any gaps will be assumed to be non-clinical laboratory work periods.	Period Employed				SPECIALTY**												
					Position Held *	Microbiology	Serology	Chemistry	Hematology	Cytology	Radioimmunoassay	Toxicology	Virology	Immunohematology	Histocompatibility	Other(List in 12 Remarks)	
	From		To														
Mo.	Yr.	Mo.	Yr.														

*Indicate position(s) using abbreviations shown in Item 6. **Indicate with "H" or "M" whether high or moderate complexity testing was performed in each specialty.

12. Remarks (Add information pertinent to your education, training, employment, etc., not included above).

13. I qualify for certification under Rule 64-57-2 for the following reasons (Check all that apply):

Certified by ASCP AMT NCA ISCLT/AAB Other (specify)

- Certified under any other applicable federal program (specify) e.g. HHS/HEW_____.
- Was performing clinical laboratory practitioner tasks in a clinical laboratory in West Virginia on July 7, 1989.
- Meets CLIA '88 qualifications (42 CFR -493.1423) for persons performing moderate complexity tests up to April 24, 1995.
- Meets CLIA '88 qualifications (42 CFR-493.1489) for persons performing high complexity tests up to April 24, 1995.
- Cytotechnologist (42 CFR-493.1483) for persons performing cytological examinations.

14. I do not meet any of the above conditions for certification but I am submitting a statement from my director that I have had training to provide me with the skills to perform the laboratory testing which I perform (page 6). The tests that I perform are listed on page 7.

Name of Applicant: _____

Name of Laboratory: _____

Type of CLIA Certificate: _____

CLIA Certificate Number: _____

QUALIFICATIONS (UNDER 64-57-5.5)

To be completed by applicant

- I am employed in a clinical laboratory which holds a CLIA certificate other than a certificate of waiver, and
- I am submitting with this application documentation that I have at least a high school diploma, a GED, or equivalent approved by the State Department of Education.

Signature of Applicant (sign in ink) _____ **Date** _____

Please print name _____

To be completed by Laboratory Director (PLEASE CHECK ALL THAT APPLY.)

- I verify that the applicant has had training designed to provide him/her the following with respect to the specific tests he/she will perform: (List all tests on page 8).
- The skills required for proper specimen collection, including patient preparation, if applicable, labeling, handling, preservation or fixation, processing or preparation, transportation and storage of specimens;
- The skills required for implementing all standard laboratory procedures;
- The skills required for performing each test method and for proper instrument use;
- The skills required for performing preventive maintenance, trouble shooting and calibration procedures related to each test performed;
- A working knowledge of reagent stability and storage;
- The skills required to implement the quality control policies and procedures of the laboratory;
- An awareness of the factors that influence test results; and
- The skills required to assess and verify the validity of patient test results through the evaluation of quality control sample values prior to reporting patient test results, and Provided further: That, in the event that the individual is to perform additional tests, he or she shall submit to the secretary documentation of training related to the additional tests in the skills, knowledge, and awareness as required by Sections 5.56 of this rule.

Signature of Current Laboratory Director (sign in ink) _____ **Date** _____

Please print name _____

16. List tests for which applicant has been trained and is competent to perform.

(Tests may be categorized as Chemistry, Hematology, etc. List each instrument used, if applicable.)

TEST	REAGENT/TEST KIT	INSTRUMENTATION	COMPLEXITY

(If more space is needed, this page may be copied).

VERIFICATION: I certify that all of the statements made in this form are true, complete and correct to the best of my knowledge and belief and are made in good faith.

17. Signature of Applicant (sign in ink) _____ Date _____

Please print name _____

VERIFICATION: I have reviewed the entries made herein and to the best of my knowledge they are true, complete and correct.

18. Signature of Current Laboratory Director (sign in ink) _____ Date _____

Please print name _____

Please submit the following documentation, as needed:

1. Copy of high school diploma/GED certificate.
2. Copy of diploma for degree.
3. Copy of certificate for board certification (or copy of current membership card).
4. Job description, if currently employed.

(PLEASE RETURN ALL 8 PAGES, COMPLETED AS APPLICABLE)