Clinical Laboratory Evaluation Program
Wadsworth Center
New York State Department of Health
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Albany, NY 12237
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Web: www.wadsworth.org/regulatory/clep/limited-service-lab-certs

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. ***SPECIAL NOTE: COVID-19 *Antigen*, COVID-19 *Molecular*, and/or COVID-19 *Antibody* testing may only be performed using a device approved for use in limited service laboratories. The current list of approved devices is posted on our website (this list will be revised as new tests are approved). Non-DOT breath alcohol testing must be performed using an FDA approved IVD Over-The-Counter device.**

1.	Test Procedure Name:		Request:	☐ Add ☐ Delete
2.	Test Procedure Name:		Request:	☐ Add ☐ Delete
3.	Test Procedure Name:		Request:	☐ Add ☐ Delete
4.	Test Procedure Name:		Request:	☐ Add ☐ Delete
5.	Test Procedure Name:		Request:	☐ Add ☐ Delete
6.	Test Procedure Name:		Request:	☐ Add ☐ Delete
7.	Test Procedure Name:		Request:	☐ Add ☐ Delete
8.	Test Procedure Name:		Request:	☐ Add ☐ Delete
9.	Test Procedure Name:		Request:	☐ Add ☐ Delete

COMMUNITY SCREENING:	Indicate whether your laboratory or laboratory network will perform off-site community screening events.	Request:	☐ Add ☐ 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)
_____	_____	_____

SPECIAL NOTICE

Return this change form and any accompanying documentation by mail only.