Contra Costa County Health Services Department

Public Health Division

NONDIAGNOSTIC GENERAL HEALTH ASSESSMENT RENEWAL FORM

This registration form must be completed annually and received by the Contra Costa County Public Health Department <u>at least 30 days</u> prior to operating a program of nondiagnostic general health assessment.

PART 1: ADMINISTRATAION

A. **Name of Organization or Operator**: _____

Permanent Address: _____

City: _____State_____ Zip Code: _____

Bus. Ph: ( ) _____ Fax: ( ) _____ CLIA #:_____ Exp:_____

B. **Name of Owner**: _____

Address (if Different Than Above): _____

City: _____State_____ Zip Code: _____

Business Phone: ( )_____ Fax: ( ) _____

C. **Supervisory Committee Members**:

Name of Physician: _____

Address: _____

_____ _____ Business Phone: ( ) _____

City State Zip Code

California Medical License #: _____Expiration: _____

Name of Clinical Laboratory Scientist: _____

Address: _____

_____ _____ Business Phone: ( ) _____

City State Zip Code

California Clinical Laboratory Scientist License #: _____ Expiration: _____

D. **Record Storage**

All operators must have a permanent address where records of testing and protocols shall be stored for the purpose of review for at least one year after testing has been completed. The <u>Contra Costa County</u> Health Officer must be notified in writing within 30 days of any change in record storage location.

Record Storage Address: _____

_____ _____ Business Phone: ( ) _____

City State Zip Code

PART 2: ASSESSMENT PROGRAM

A. **Location where assessment are to be performed** (complete a separate Supplemental form 2A for each additional location):
Name of Location: _____

Permanent Address: _____

_____ _____ Business Phone: ( ) _____
City State Zip Code

B. **Dates and Hours Program will be Operating at this Location** (attach additional sheets if necessary):

Date	Hours	Date	Hours

NOTE: ANY CHANGES IN TIMES, DATES OR LOCATION MUST BE REPORTED IN WRITING TO THE HEALTH DEPARTMENT AT LEAST 24 HOURS PRIOR TO THE OPERATION OF THE PROGRAM.

C. Nondiagnostic Test Conducted at this location.

(✔)	Test	Equipment Name	Manufacturer
	TOTAL CHOLESTEROL		
	HIGH DENSITY LIPOPROTEIN (HDL)		
	LOW DENSITY LIPOPROTEIN (LDL)		
	TRIGLYCERIDES		
	BLOOD GLUCOSE		
	HEMOGLOBIN		
	DIPSTICK URINALYSIS		
	FECAL OCCULT BLOOD		
	URINE PREGNANCY		

D. List of all employees for this location (attach additional sheets if necessary).

Name	Title	(✔) Authorized to perform skin puncture	
		Yes	No

NOTE: Include documentiation of authorization to perform skin puncture for each individual checked "Yes" above.

PART 3: COMPLIANCE

All assessment programs must be operated per § 1244 of the California Business and Professions Code. Please answer each of the questions listed below.

Yes	No	
[ ]	[ ]	The organization/operator listed on this application has and will continue to operate in accordance with all applicable Federal, State and County regulations in its provision of Non-diagnostic General Health Assessment Programs.
[ ]	[ ]	An annual review by the supervisory committee of all written protocols has been performed and documented with a signed and dated statement made by both supervisory committee members. A copy of this document is included with this application.
[ ]	[ ]	All protocols and procedures followed in this program have been submitted to the Contra Costa County Non-diagnostic General Health Assessment Office for review or all new procedures are enclosed with this application.

PART 4: FEES (LICENCE VALID ONE YEAR)

- Annual fee: $200

Make Checks Payable to: **Contra Costa County**

Return Application to: **Contra Costa Public Health Lab**
NGHA Program
2500 Alhambra Avenue, Room 209
Martinez, CA 94553

PART 5: LICENSE

Name of Person Requesting License: _____ _____
Phone no.

Address if different than above: _____

_____ _____ _____ _____
City State Zip code email address

I certify that the above information is accurate and complete and that I am aware of the laws and regulations that apply to non-diagnostic testing in the State of California and in the County of Contra Costa in which testing is to be performed.

_____ _____
Applicant's signature Date of Application

FOR OFFICIAL USE ONLY

Reviewed by:_____ Date: _____ Date Received:_____

License #:_____Date:_____ Exp. Date: _____

PART 2A: ADDITIONAL ASSESSMENT PROGRAM LOCATION

Complete a separate PART 2A for each location where assessments are to be performed.

A. **Name of Organization or Operator**: _____

Permanent Address: _____

_____ _____
City State Zip Code

Business Phone: ( ) _____ Fax #: ( ) _____ CLIA #:_____

B. **Location where assessments are to be performed (complete a separate Supplemental Form 2A for each additional location):**

Name of Location: _____

Permanent Address: _____

_____ _____ Business Phone: ( ) _____
City State Zip Code

C. Dates and Hours Program will operate at this location (attach additional sheets if necessary):

Date	Hours	Date	Hours

Note: Any changes in dates, times, or locations must be reported in writing to the Health Department at least 24 hours prior to the operation of the program.

D. **Nondiagnostic Tests Conducted at this location**:

(✔)	Test	Equipment Name	Manufacturer
	TOTAL CHOLESTEROL		
	HIGH DENSITY LIPOPROTEIN (HDL)		
	LOW DENSITY LIPOPROTEIN (LDL)		
	TRIGLYCERIDES		
	BLOOD GLUCOSE		
	HEMOGLOBIN		
	DIPSTICK URINALYSIS		
	FECAL OCCULT BLOOD		
	URINE PREGNANCY		

E. List of Employees for this location (attach additional sheets if necessary).

Name	Title	(✔) Authorized to perform skin puncture	
		Yes	No

NOTE: Include documentation of authorization to perform skin puncture for each individual checked "Yes" above.

F. LICENSE

Name of Person Requesting License: _____ _____
Phone no.

Address if different than above: _____

_____ _____ _____ _____
City State Zip code email address

I certify that the above information is accurate and complete and that I am aware of the laws and regulations that apply to non-diagnostic testing in the State of California and in the County of Contra Costa in which testing is to be performed.

_____ _____
Applicant's signature Date of Application

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Reviewed by:_____ Date: _____ Received Date: _____

License #:_____ Date Issued: _____Exp. Date: _____