



## CLINICAL LABORATORY PRACTITIONER LICENSURE AND CERTIFICATION INITIAL APPLICATION

Office of Laboratory Services  
Personnel Licensure  
167 11<sup>th</sup> Avenue  
South Charleston, WV 25303  
304.205.8914

**PLEASE DO NOT RETURN THIS PAGE**

### INSTRUCTIONS

Complete this application in its entirety. Failure to complete this application, including providing the required documents from the chart on page 3, will result in the inability to process your request for licensure. Please contact us if you have questions about the application.

### REQUIRED DOCUMENTATION

Please see the Licensure chart on page 3 for the required documents specific to your application. Documents may be returned via the methods listed in the "submission" section below. **IF YOU ARE NOT APPLYING FOR A POCT OR TRAINEE LICENSE, DO NOT COMPLETE OR RETURN THE FORMS ON PAGES 7 AND 8.**

### INTERNATIONAL APPLICANTS

Please include either documentation of ASCP<sup>i</sup> certification OR a foreign equivalency evaluation and verifiable documentation of experience with your application. Ensure that you provide the contact information for your staffing agency or sponsor, as the license documents will be mailed directly to that entity.

### SUBMISSION

This document is a fillable PDF. It may be completed electronically, e-signed, saved, and returned via email. If it is being printed for manual filling, it can be returned via one of the following options:

- a. Mail:  
WV Office of Laboratory Services  
ATTN: Personnel Licensure  
167 11<sup>th</sup> Avenue  
South Charleston, WV 25303
- b. Fax: 304-746-0658
- c. Email: [DHHROLSCLP@wv.gov](mailto:DHHROLSCLP@wv.gov)

### PAYMENTS

- a. Check or money order payable to "Department of Health." **CASH NOT ACCEPTED**
- b. Online payment at <https://epay.wvsto.com/processipay/default.aspx?GUID=E9343FE5-4550-43E5-A360-7BDF7E14E07D> (PAY ADDITIONAL FEES link at the bottom of the page listed above-do NOT use the link to renew online)
- c. **LICENSURE FEES ARE NONREFUNDABLE**

**PLEASE DO NOT RETURN THIS PAGE**

**WV LICENSURE CATEGORIES AND ROUTES**

<b>CATEGORY</b>	<b>EDUCATION/EXPERIENCE ROUTES</b>	<b>COMPLEXITY</b>	<b>DOCUMENTATION</b>
<b>PATHOLOGIST ASSISTANT (PA)</b>	<b>A.</b> Degree in Pathologist Assistant studies from NAACLS accredited program + national certification	High, moderate	<b>A.</b> Degree/transcript, certification
<b>MEDICAL LABORATORY SCIENTIST (MLS)</b>	<b>A.</b> BS in MT/MLS + national/int'l certification <sup>†</sup> <b>B.</b> Previous WV MLT license + bachelor's degree + national/int'l certification <sup>†</sup> <b>C.</b> Other applicable BS + 1-year experience/training (chemical, physical, or biological science) <b>D.</b> Other grandfather provision	High, moderate	<b>A.</b> Degree/transcript, certification <b>B.</b> Degree/transcript, certification <b>C.</b> Degree/transcript, training confirmation <sup>‡</sup> <b>D.</b> Contact OLS
<b>LABORATORY TECHNICIAN (MLT)</b>	<b>A.</b> AAS in CLT/MLT + national/int'l certification <sup>†</sup> <b>B.</b> Other associate of science degree + 1-year experience/training <b>C.</b> Qualifying college credits + 1-year of experience/training <b>D.</b> Other grandfather provision	High, moderate	<b>A.</b> Degree/transcript, certification <b>B.</b> Degree/transcript, training confirmation <sup>‡</sup> <b>C.</b> Transcript, training confirmation <sup>‡</sup> <b>D.</b> Contact OLS
<b>CYTOTECHNOLOGIST (CT)</b>	<b>A.</b> Graduated from CAAHEP or CAHEA accredited program <b>B.</b> National certification in cytotechnology	High, moderate	<b>A.</b> Degree/transcript <b>B.</b> Certification
<b>HISTOLOGIST (H)</b>	<b>A.</b> Meets CLIA requirements (see MLT qualifications) + national certification as histotechnologist or histotechnician <b>B.</b> Meets CLIA requirements + 1 year of training/experience in grossing	High, moderate*	<b>A.</b> Degree/transcript, certification <b>B.</b> Degree/transcript, training confirmation <sup>‡</sup>
<b>POINT OF CARE TECHNICIAN (POCT)</b>	<b>A.</b> HS or equivalent + documentation of training specific to testing performed and reported	Moderate	<b>A.</b> HS diploma, job description, training agreement, training log
<b>TRAINEE (T)</b>	<b>A.</b> Enrolled in educational program <b>B.</b> Employed by clinical laboratory	High, moderate <sup>#</sup>	<b>A.</b> Program description, transcript <b>B.</b> Transcript, job description, training agreement, training log

\* With direct supervision by a pathologist or pathologist assistant.

† Applicants with international certification must also include a foreign equivalency degree evaluation.

‡ Training confirmation is required **only if** moving from a trainee license to an initial PA, MLS, MLT, CT, or H license.

# With direct supervision.



**LABORATORY PRACTITIONER LICENSURE AND CERTIFICATION  
INITIAL APPLICATION**

**Office of Laboratory Services  
Personnel Licensure  
167 11<sup>th</sup> Avenue  
South Charleston, WV 25303  
304.205.8914**

*An individual employed as a clinical laboratory practitioner in West Virginia must establish his or her qualifications under the Clinical Laboratory Personnel Licensure and Certification legislative rule (64 CSR 57). Exceptions are listed under Section 1.6.c. of the rule. The Laboratory Personnel Licensure program must collect the following information in order to determine whether the applicant meets the requirements for licensure. The authority to collect this information is granted in Section 5 of the aforementioned rule. Pursuant to Sections 7a and 7b of the federal Privacy Act (5 U.S.C. §552a), you are not required to submit your Social Security Number (SSN) on this application. Inclusion of your SSN is completely voluntary and optional. If provided, it will be kept confidential and used internally within the licensure program for identification purposes only. OLS will not provide your SSN to any other local, state, or federal agency, or individual, unless subject to federal requirements, or unless express consent to do so is received.*

**INSTRUCTIONS**

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**1. DEMOGRAPHIC INFORMATION**

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN/FORMER NAME	
HOME/MAILING ADDRESS		CITY	STATE	ZIP
DATE OF BIRTH (MM/DD/YYYY)	SSN (optional)	EMAIL ADDRESS	PHONE NUMBER	

**2. LABORATORY INFORMATION**

If you are affiliated with a laboratory testing facility within WV in which you are currently or will be performing testing, complete this section (includes employment or an offer for employment, but not student clinical rotations). If not applicable, check here:

SUPERVISOR/MANAGER	LAB/FACILITY NAME	EMAIL	PHONE
CLIA NUMBER	ADDRESS	CITY	ZIP

**3. TRAINING PROGRAM/STAFFING AGENCY CONTACT INFORMATION**

If you are a student in a laboratory training program or an employee of a staffing agency, complete this section. If not applicable, check here:

PROGRAM/AGENCY NAME	PROGRAM/AGENCY CONTACT PERSON	EMAIL	PHONE
ADDRESS		CITY	STATE ZIP

**4. MAILING INFORMATION**

If you wish to have your licensure renewal forms, cards, and certificates mailed directly to your employer for an additional cost of \$10, check here .

[Otherwise, all licensure forms, cards, and certificates will be mailed to your home address (exception: international applicant licenses are sent directly to the staffing agency or laboratory for no additional charge)]

**5. PREVIOUS LICENSURE INFORMATION**

If you are currently licensed or previously held a laboratory license in West Virginia, complete this section.

If not applicable, check here:  (If information is not known, write "unknown")

Previous license number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Previous license category: Trainee MLT MT/MLS POCT Other \_\_\_\_\_

**6. RECIPROCITY INFORMATION**

If you are currently licensed or previously held a laboratory license in another state, complete this section.

If not applicable, check here:

State \_\_\_\_\_ License number \_\_\_\_\_ Expiration date \_\_\_\_\_

Has this license been subject to revocation, suspension, or other disciplinary action? Yes No

**7. TESTING COMPLEXITY**

What complexity of testing do you intend to perform? Select all that apply.

High Moderate Waived

**8. TYPE OF FACILITY**

Select one type of facility from the list below that best matches the description of the laboratory. If not closely related to any option, please describe on the "other" line.

- Hospital Physician Office Public Health
- Clinic County Health Department Reference Lab
- Other: \_\_\_\_\_

**9. REQUESTED LICENSE TYPE**

Please check one box for the license category and select the single corresponding route for that category by which you qualify. See the licensing category chart to find the applicable route.

Category		Route	Cost
<input type="checkbox"/>	Pathologist Assistant (PA)	<input type="checkbox"/> A	\$25
<input type="checkbox"/>	Medical Laboratory Scientist (MLS)	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	\$25
<input type="checkbox"/>	Medical Laboratory Technician (MLT)	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F	\$25
<input type="checkbox"/>	Cytotechnologist (CT)	<input type="checkbox"/> A <input type="checkbox"/> B	\$25
<input type="checkbox"/>	Histologist (H)	<input type="checkbox"/> A <input type="checkbox"/> B	\$25
<input type="checkbox"/>	Point of Care Technician (POCT)	<input type="checkbox"/> A	\$25
<input type="checkbox"/>	Trainee	<input type="checkbox"/> A <input type="checkbox"/> B	\$0

**10. COLLEGES, UNIVERSITIES, OR OTHER SCHOOL(S) ATTENDED**

Institution Name City and State	Date From	Date To	Major	Degree, Diploma, or Certificate	Date Conferred
_____	MM	MM			MM
_____	YYYY	YYYY			YYYY
_____	MM	MM			MM
_____	YYYY	YYYY			YYYY
_____	MM	MM			MM
_____	YYYY	YYYY			YYYY

**11. ACCREDITED CLINICAL LABORATORY TRAINING PROGRAM NOT LISTED ABOVE** (military programs, on-the-job training, certificate programs, etc.)

Institution Name City and State	Date From	Date To	Program Title	Degree, Diploma, or Certificate	Date Conferred
_____	MM	MM			MM
_____	YYYY	YYYY			YYYY
_____	MM	MM			MM
_____	YYYY	YYYY			YYYY
_____	MM	MM			MM
_____	YYYY	YYYY			YYYY

**12. LICENSES, CERTIFICATIONS, OR REGISTRATIONS**

Name of Granting Agency	Certification Title	Date Granted	License/Certification/ Registration Number
		MM YYYY	
		MM YYYY	
		MM YYYY	

**13. PREVIOUS CLINICAL LABORATORY EXPERIENCE**

Place an X in the box(es) corresponding to the experience in each testing specialty for each listed facility.

<p>Only document employment in which you received laboratory testing experience. Phlebotomy need not be listed.</p> <p>Job Title, Institution Name, City, and State</p>	<p>Date From</p>	<p>Date To</p>	<p>Microbiology</p>	<p>Serology</p>	<p>Chemistry</p>	<p>Hematology</p>	<p>Cytology</p>	<p>Urinalysis</p>	<p>Toxicology</p>	<p>Virology</p>	<p>Immunohematology (BB)</p>	<p>Histocompatibility</p>	<p>Other (note below)</p>
<p>_____</p> <p>_____</p> <p>_____</p>	<p>____</p> <p>MM</p> <p>____</p> <p>YYYY</p>	<p>____</p> <p>MM</p> <p>____</p> <p>YYYY</p>											
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Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**14. VERIFICATION**

By signing this application, I certify that all statements made in this form are true, complete, correct to the best of my knowledge and belief, and are made in good faith. I agree to submit the required documentation and certify that I understand my application cannot be processed until it is received.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**LABORATORY TRAINING AGREEMENT (POCT or TRAINEE APPLICANTS ONLY)**

**To be completed by the applicant:**

- I am a student who is completing a rotation in a clinical laboratory, which holds a nonwaived CLIA certificate, and I am submitting documentation of the successful completion of the courses I have completed thus far in the program;
- OR
- I am employed by a laboratory which holds a nonwaived CLIA certificate, and I am submitting documentation that I hold a minimum of a high school diploma or equivalent, approved by the State Department of Education;
- AND
- I agree that I will not perform testing until I receive the proper training.

**Applicant Printed Name** \_\_\_\_\_ **Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_

**To be completed by the educational Program Director or facility Laboratory Director/Manager:**

**I hereby verify that the applicant will receive the appropriate training to provide him/her the following skills with respect to each specific test he/she will perform (list all on page 8), as follow:**

- Specimen collection, including patient preparation when applicable, labeling, handling, preservation, fixation, processing, preparation, transportation, and storage
- Implementation of all standard laboratory procedures
- Performance of each test method and proper instrument usage
- Performance of preventive maintenance, troubleshooting, calibration, and quality control for each test
- Working knowledge of reagent stability and storage
- Implementation of quality control policies and procedures of the laboratory
- Awareness of factors influencing test results
- Assessment and verification of the validity of test results through evaluation of quality controls samples prior to reporting.

**Additionally, I agree to the following provisions:**

- If the individual is to perform additional testing to what was listed in this application, I agree to submit documentation of training related to these additional tests as required by Section 5.5.b of the Rule
- I attest that a trainee performing high complexity testing will have a minimum of 3 months of training or experience for each specialty in which testing is performed per the CLIA regulations (N/A for POCT)

**Name of Laboratory/Educational Program** \_\_\_\_\_

**CLIA Number** \_\_\_\_\_ **Certificate Type:**  **Compliance**  **Accreditation**  **PPMP**

**Signee Printed Name** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Signee Title** \_\_\_\_\_ **Date** \_\_\_\_\_

**LABORATORY TEST/METHOD TRAINING LOG (POCT OR TRAINEE APPLICANTS ONLY)**

Specialty*	Test Name**	Kit/Method Name	Instrumentation	Complexity
<b>EXAMPLES</b>				
Hematology	Manual differential	Microscopy	Microscope	<input type="checkbox"/> waived <input type="checkbox"/> moderate <input checked="" type="checkbox"/> high
Chemistry	General automated chemistry	General automated chemistry	Siemens Vista 1500	<input type="checkbox"/> waived <input checked="" type="checkbox"/> moderate <input type="checkbox"/> high
				<input type="checkbox"/> waived <input type="checkbox"/> moderate <input type="checkbox"/> high
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\*Specialties include microbiology, serology, chemistry, hematology, cytology, urinalysis, toxicology, virology, blood bank, histocompatibility, or other [list other]

\*\*Please document general automated chemistry (moderate complexity) training as shown in the example. It is not necessary or advisable to list each individual assay.

If more space is needed, please use multiple copies of the form.