# CLINICAL LABORATORY PRACTITIONER LICENSURE
# INITIAL QUALIFICATION APPRAISAL AND APPLICATION

**West Virginia Department of Health and Human Resources**
**Office of Laboratory Services**
**167 11th Avenue**
**South Charleston, WV 25303**

*An individual employed as a clinical laboratory practitioner in West Virginia must establish his or her qualifications under the Clinical Laboratory Technician and Scientist Licensure and Certification legislative rule (64 CSR 57). Exceptions are listed under Section 1.6.c. of the rule. The OLS 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:*** *ALL FIELDS IN* ***BOLD TYPE*** *ARE REQUIRED FOR THE PROCESSING OF YOUR APPLICATION. FAILURE TO INCLUDE ALL REQUIRED INFORMATION WILL RESULT IN THE INABILITY TO PROCESS YOUR REQUEST FOR LICENSURE. PLEASE CONTACT US IF YOU HAVE QUESTIONS ABOUT THE APPLICATION.*

***POCT AND TRAINEE APPLICANTS: PLEASE REVIEW THE ADDITIONAL INSTRUCTIONS ON PAGE 6, SECTION 18, BEFORE COMPLETING THIS APPLICATION***

## 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

**Are you affiliated with a laboratory testing facility within WV in which you are currently or will be performing testing?** This includes employment (or have received an offer for employment, directly or via staffing agency pending receipt of licensure) but not student clinical rotations. □**Yes*** □**No****
***If yes, please fill out the information below.***
***If no, skip this question and see section 18 for instructions before completing this application.*

| **LAB/FACILITY NAME** | **LAB ADDRESS** | **LAB CITY** | **LAB STATE** | **LAB ZIP** |
|---|---|---|---|---|
| | | | | |
| **LAB CONTACT (SUPERVISOR/MANAGER)** | | **CONTACT PHONE** | **CONTACT EMAIL** | |
| | | | | |
| **LAB PHONE** | **CLIA LAB DIRECTOR (MEDICAL) NAME** | **CLIA NUMBER** | **LAB COUNTY** | |
| | | | | |

3. **TRAINING PROGRAM/STAFFING AGENCY CONTACT INFORMATION**
**Are you a student in a laboratory training program or an employee of a staffing agency?**
**□Yes* □No**
***If yes, please fill out the chart below.***
*If student, please list your clinical rotation sites on the Multiple Site form on page 9 and return with the application. If site schedule is unknown at the time of application, please keep a copy of the form and provide updates as they are received.*

| PROGRAM/AGENCY NAME | PROGRAM/AGENCY CONTACT PERSON | EMAIL | PHONE |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

4. **MULTIPLE SITES**
**Are/will you be testing in multiple locations in WV? This includes rotating to other facilities under the same employer, working for more than one employer, or visiting multiple locations for clinical training.**
**□Yes* □No**
***If yes, please fill out the form on page 9.***

5. **MAILING INFORMATION**
**Do you wish to have your licensure renewal forms, cards, and certificates mailed directly to your employer for an additional cost of $10?** Otherwise, all licensure forms, cards, and certificates will be mailed to your home address (exceptions: international applicant licenses are sent directly to the staffing agency or laboratory for no additional charge).
**□Yes* □No**
***If yes, please include this fee with your payment.***

6. **PREVIOUS LICENSURE INFORMATION**
**Have you ever held a laboratory practitioner OR trainee license in the state of West Virginia?**
**□Yes* □No**
***If yes, please complete the following questions. If information not known, write "unknown."***
Previous license number: __________________ Expiration date: ______________________
Previous license category: □Trainee □MLT □MT/MLS □POCT □Other ____________

7. **RECIPROCITY INFORMATION**
**Have you previously held, or do you currently hold, a laboratory license in another state?**
**□Yes* □No**
***If yes, please complete the following questions.***
State _________________ License number ____________________Expiration date _____________
Has this license been subject to revocation, suspension, limitation, or other form of disciplinary action?
□Yes □No

8. **TESTING COMPLEXITY**
**What complexity(ies) of testing do you intend to perform? Select all that apply.**
**□High □Moderate □Waived**

9. **TYPE OF FACILITY**

**Select the type of facility from the list below. If not closely related to any option, please describe on the "other" line. Choose 1 only.**

| | | |
|---|---|---|
| □**Hospital** | □**Physician Office** | □**Public Health** |
| □**Clinic** | □**County Health Department** | □**Reference Lab** |

□**Other: ________________________________________________________________**

**WV LICENSURE CATEGORIES AND ROUTES**

| CATEGORY | EDUCATION/EXPERIENCE ROUTES | COMPLEXITY | REQUIRED DOCUMENTATION |
|---|---|---|---|
| **MEDICAL LABORATORY SCIENTIST (MLS)** | A. BS in MT/MLS + national/int'l certification<br>B. Other bachelor's degree + 1-year experience/training<br>C. Passed HEW between 3/1/1986 and 12/31/1987<br>D. CLIA high complexity testing personnel before 9/1/1997<br>E. WV MT license before 6/1/2017 and meets requirements under rule | High, moderate | **A**: Bachelor's degree transcript, national/int'l** certification, job description<br>**B**: Transcript, job description<br>**C**: HEW certification, job description<br>**D and E**: Contact OLS |
| **LABORATORY TECHNICIAN (MLT)** | A. AAS in CLT/MLT + national/int'l certification<br>B. Other associate degree + 1-year experience/training<br>C. Qualifying college credits + 1-year of experience/training<br>D. HS equivalent + training program before 4/25/1995<br>E. CLIA testing personnel before 7/8/1998<br>F. WV MLT license before 6/1/2017 and meets requirements under rule | High, moderate | **A**: Associate degree transcript, national/int'l** certification, job description<br>**B and C**: Transcript, job description<br>**D**: HS diploma or equivalent, proof of training, job description<br>**E and F**: Contact OLS |
| **CYTOTECHNOLOGIST (CT)** | A. Graduated from CAAHEP or CAHEA accredited program<br>B. National certification | High | **A**: Transcript, job description<br>**B**: National certification, job description |
| **POINT OF CARE TECHNICIAN (POCT)** | A. HS or equivalent and documentation of training specific to testing performed and reported | Moderate | **A**: HS diploma, training checklist and log, job description |
| **TRAINEE** | A. Enrolled in educational program<br>B. Employed by clinical laboratory | High, moderate<br>***with supervision** | **A**: Program description, current transcript<br>**B**: College transcript, job description |

**** See section 16**

10. **REQUESTED LICENSE TYPE**

**Please check <u>one</u> box for the license category of which you are applying and select <u>one</u> corresponding route for that category from the chart above.**

| | Category | Route | Cost |
|---|---|---|---|
| □ | Medical Laboratory Scientist (MLS) | □A □B □C □D □E | $25 |
| □ | Medical Laboratory Technician (MLT) | □A □B □C □D □E □F | $25 |
| □ | Cytotechnologist (CT) | □A □B | $25 |
| □ | Point of Care Technician (POCT)* | □A | $25 |
| □ | Trainee* | □A □B | $0 |

***If applying for a Trainee or POCT license, complete the training checklist on page 7 and method training log on page 8. If applying for any other license, skip pages 7 and 8.***

## 11. COLLEGES, UNIVERSITIES, OR OTHER SCHOOL(S) ATTENDED

| Institution Name, City, and State | Date From | Date To | Major | Degree, Diploma, or Certificate | Date Conferred |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## 12. ACCREDITED CLINICAL LABORATORY TRAINING PROGRAM (IF NOT LISTED ABOVE)

| Institution Name, City, and State | Date From | Date To | Program Title | Degree, Diploma, or Certificate | Date Conferred |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## 13. LICENSES, CERTIFICATIONS, OR REGISTRATIONS

| Name of Granting Agency | Certification Title | Date Granted | License/Certification/ Registration Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**14. PREVIOUS CLINICAL LABORATORY EXPERIENCE**
**Place an M for moderate complexity and an H for high complexity in the box(es) corresponding to the experience you had in the applicable testing specialties for each listed facility.**

| Only document employment in which you received laboratory testing experience. Phlebotomy need not be listed.<br><br>Job Title,<br>Institution Name,<br>City, and State | Date From | Date To | Microbiology | Serology | Chemistry | Hematology | Cytology | Toxicology | Virology | Immunohematology (BB) | Histocompatibility | Other (note below) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ____________<br>____________<br>____________ | | | | | | | | | | | | |
| ____________<br>____________<br>____________ | | | | | | | | | | | | |
| ____________<br>____________<br>____________ | | | | | | | | | | | | |
| ____________<br>____________<br>____________ | | | | | | | | | | | | |
| ____________<br>____________<br>____________ | | | | | | | | | | | | |

**Other: ______________________________________________________________**

**________________________________________________________________________**

**________________________________________________________________________**

**15. 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 ______________**

**16. INTERNATIONAL APPLICANTS**

**Please include either documentation of ASCP[i] 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 because your license will be mailed to that contact.**

**17. 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 section 19.**

**18. NEW APPLICANTS WITHOUT CURRENT EMPLOYMENT IN WEST VIRGINIA**

**If you are applying for a license as a TRAINEE or POCT and do not yet have an employer in WV (except trainees in educational programs), please do not complete the application. Email us at DHHROLSCLP@wv.gov for instructions on how to proceed. If you are applying for an MLS, MLT, or CT license, you may complete the application without having current or expected employment in the state.**

**19. SUBMISSION**

**a. Mail:**

**WV Office of Laboratory Services**
**ATTN: Personnel Licensure**
**167 11th Avenue**
**South Charleston, WV 25303**

**b. Fax: 304-746-0658**

**c. Email: DHHROLSCLP@wv.gov**

**d. Please visit our website at https://dhhr.wv.gov/ols/regulatory/Pages/Licensure.aspx for more information.**

**20. PAYMENTS**

**a. Check or money order via mail; CASH NOT ACCEPTED**

**b. Online payment at https://epay.wvsto.com/processepay/default.aspx?GUID=E9343FE5-4550-43E5-A360-7BDF7E14E07D (PAY ADDITIONAL FEES link at the bottom of the page listed above)**

## 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** (microbiology, serology, chemistry, hematology, cytology, urinalysis, toxicology, virology, blood bank, histocompatibility, or other [list other]) | **Test Name** | **Kit/Method Name** | **Instrumentation** | **Complexity** |
|---|---|---|---|---|
| EXAMPLE Hematology | CBC with manual differential | Automated instruments, Microscopy | Beckman Coulter LH500, microscope | □waived<br>□moderate<br>☑high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |
| | | | | □waived<br>□moderate<br>□high |

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

**MULTIPLE SITE FORM**

Licensee/applicant name: ___________________________________________________________

Licensee/applicant license number: _________ Effective date: _________ Expiration date: _________

License category: □MLS □MLT □CT □POCT □TRAINEE (student) □TRAINEE (employed)

ORIGINAL FACILITY (from application) OR FIRST CLINICAL SITE
Date begin: _________ Date end: _________

| LAB/FACILITY NAME | LAB ADDRESS | LAB CITY | LAB STATE | LAB ZIP |
|---|---|---|---|---|
| | | | | |

| LAB CONTACT (SUPERVISOR/MANAGER) | CONTACT PHONE | CONTACT EMAIL |
|---|---|---|
| | | |

| LAB PHONE | CLIA LAB DIRECTOR (MEDICAL) NAME | CLIA NUMBER | LAB COUNTY |
|---|---|---|---|
| | | | |

ADDITIONAL FACILITY 1
Date begin: _________ Date end: _________ □Site Change □Additional Job

| LAB/FACILITY NAME | LAB ADDRESS | LAB CITY | LAB STATE | LAB ZIP |
|---|---|---|---|---|
| | | | | |

| LAB CONTACT (SUPERVISOR/MANAGER) | CONTACT PHONE | CONTACT EMAIL |
|---|---|---|
| | | |

| LAB PHONE | CLIA LAB DIRECTOR (MEDICAL) NAME | CLIA NUMBER | LAB COUNTY |
|---|---|---|---|
| | | | |

ADDITIONAL FACILITY 2
Date begin: _________ Date end: _________ □Site Change □Additional Job

| LAB/FACILITY NAME | LAB ADDRESS | LAB CITY | LAB STATE | LAB ZIP |
|---|---|---|---|---|
| | | | | |

| LAB CONTACT (SUPERVISOR/MANAGER) | CONTACT PHONE | CONTACT EMAIL |
|---|---|---|
| | | |

| LAB PHONE | CLIA LAB DIRECTOR (MEDICAL) NAME | CLIA NUMBER | LAB COUNTY |
|---|---|---|---|
| | | | |

ADDITIONAL FACILITY 3
Date begin: _________ Date end: _________ □Site Change □Additional Job

| LAB/FACILITY NAME | LAB ADDRESS | LAB CITY | LAB STATE | LAB ZIP |
|---|---|---|---|---|
| | | | | |

| LAB CONTACT (SUPERVISOR/MANAGER) | CONTACT PHONE | CONTACT EMAIL |
|---|---|---|
| | | |

| LAB PHONE | CLIA LAB DIRECTOR (MEDICAL) NAME | CLIA NUMBER | LAB COUNTY |
|---|---|---|---|
| | | | |

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