

**APPLICATION FOR RENEWAL OF LICENSE for  
CLINICAL LABORATORY PRACTITIONER**  
 WV DHHR / OFFICE OF LABORATORY SERVICES  
 ATTN: PERSONNEL LICENSURE  
 167 11<sup>TH</sup> AVENUE  
 SOUTH CHARLESTON, WV 25303  
 Phone (304) 558-3530 extension 2105 | Fax (304) 558-2006

**PLEASE FILL IN THE INFORMATION IN THE AREAS PROVIDED**

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	TELEPHONE #	
ADDRESS	CITY	STATE	ZIP	LICENSE #	EXPIRATION DATE

**LAB INFORMATION**

LAB NAME	LAB ADDRESS	LAB CITY	LAB STATE	LAB ZIP
CLIA #	TESTING COMPLEXITY	LAB DIRECTOR	LAB TELEPHONE	PREVIOUS EMPLOYER
	<input type="checkbox"/> HIGH <input type="checkbox"/> MODERATE <input type="checkbox"/> WAIVED <span style="color: red; font-size: small;">MARK ALL THAT APPLY</span>			

**EDUCATION (Mark (X) in the correct box)**

HOSPITAL DIPLOMA	HS OR EQUIV	AS	BS/BA	REGENTS/BA	MS/MA	MD/DO/PHD

**TITLE (Mark (X) in the correct box)**

MT	MLT	CLA/CLT	RN	LPT	MED ASSIST	MD	MICRO	CHEM	SPECIFY OTHER

**ADDITIONAL INFORMATION**

CATEGORY	CERTIFICATION AGENCY	YEARS OF EXPERIENCE

**LIST ANY CHANGES IN TESTING WHICH YOU ROUTINELY PERFORM IN YOUR LABORATORY**

If there are no changes from last year's application – indicate **NO CHANGE** by checking box.

TEST	REAGENT/TEST KIT	INSTRUMENT	COMPLEXITY

**CLINICAL LABORATORY PRACTITIONER'S CONTINUING EDUCATION DOCUMENTATION**

Please submit the required 10 contact hours of continuing education below.

PROGRAM TITLE and BRIEF DESCRIPTION	LOCATION and SPONSOR	TYPE OF TRAINING									INCLUSIVE DATES	TOTAL CONTACT HOURS
		LECTURE	WORKSHOP	TELECONFERENCE	AUDIO CONFERENCE	CORRESPONDENCE	IN-SERVICE	MFG. REPRESENTATIVE	OTHER	TEACHING /PRESENTATION		

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

**Signature of Applicant (sign in ink)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Supervisor (sign in ink)** \_\_\_\_\_ **Date** \_\_\_\_\_  
 (Signature verifies the applicant has completed the CE listed above in accordance with the licensure requirements.)

Please mail a \$25.00 check made payable to **WV DHHR State Lab** and this completed and signed application to the address below:

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