LABORATORY PERSONNEL LICENSURE RENEWAL 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 RENEWAL. PLEASE CONTACT US IF YOU HAVE QUESTIONS ABOUT THE APPLICATION.*
SEE PAGE 3 FOR SUBMISSION INSTRUCTIONS.

1. DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	FORMER NAME

HOME/MAILING ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER *(optional)*	PHONE NUMBER	EMAIL ADDRESS

□ **Check here if any of the above information has changed and indicate the changes below**

_____

_____

_____

2. LABORATORY INFORMATION (□N/A)

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

□ **Check here if any of the above information has changed and indicate the changes below**

_____

_____

_____

3. TRAINING PROGRAM/STAFFING AGENCY CONTACT INFORMATION (□N/A)

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

ADDRESS	CITY	STATE	ZIP

□Check here if any of the above information has changed and indicate the changes below

_____

_____

_____

4. MULTIPLE SITES

□Check here if you need to add or remove a multiple site from your record; complete the multiple site form on page 8.

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. TESTING COMPLEXITY

□ Check here if any of following information has changed and indicate the changes below.

What complexity(ies) of testing do you perform? Select all that apply.

□High □Moderate □Waived

7. REQUESTED CHANGE TO LICENSE TYPE

□Check here if you have completed a year of training, graduated from an educational program, or obtained national certification and would like to change your license category.

Choose the desired license type by checking the box for the appropriate category and route; submit copies of your degree, transcripts, or national certification. See the table on the next page for the corresponding routes and required documentation. If you have completed a year of training under a trainee license, also complete the training verification form on page 5.

	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

8. TRAINEE LICENSE RENEWAL

□ Check here if you wish to renew a trainee license and provide an explanation as to why a renewal is necessary. These are assessed on a case-by-case basis.

_____

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 B. Other bachelor's degree + 1-year experience/training C. Passed HEW between 3/1/1986 and 12/31/1987 D. CLIA high complexity testing personnel before 9/1/1997 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 **B**: Transcript, job description **C**: HEW certification, job description **D and E**: Contact OLS
LABORATORY TECHNICIAN (MLT)	A. AAS in CLT/MLT + national/int'l certification B. Other associate degree + 1-year experience/training C. Qualifying college credits + 1-year of experience/training D. HS equivalent + training program before 4/25/1995 E. CLIA testing personnel before 7/8/1998 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 **B and C**: Transcript, job description **D**: HS diploma or equivalent, proof of training, job description **E and F**: Contact OLS
CYTOTECHNOLOGIST (CT)	A. Graduated from CAAHEP or CAHEA accredited program B. National certification	High	**A**: Transcript, job description **B**: National certification, job description

9. **Does your national certification (ASCP, AMT, etc.) require certification maintenance?**
   □Yes □No □N/A
   If yes, please provide a copy of your certification when it is renewed.

10. **Continuing Education: Documentation of 10 hours of CE completed within the time frame of your current license must be included with this application; skip page 4 if you are including this documentation.** If you do not have evidence to provide, complete page 4 and obtain a signature from your manager/director to verify the information.
    □Check this box if you must complete page 4.

11. **□If you are a Point of Care Technician (POCT) renewing your license for the *first* time, please check the box and complete the form on page 6.**

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

    Signature of Applicant _____ Date _____

13. **SUBMISSION**
    a. **PLEASE RETURN THE FORMS ON THE FOLLOWING PAGES ONLY IF THEY APPLY TO YOU.**
    b. **Mail: WV Office of Laboratory Services**
       ATTN: Personnel Licensure
       167 11th Avenue, South Charleston, WV 25303
    c. **Fax: 304-746-0658**
    d. **Email: DHHROLSCLP@wv.gov**

14. **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- https://dhhr.wv.gov/ols/regulatory/Pages/Licensure.aspx)**

CONTINUING EDUCATION (SKIP IF SENDING CE CERTIFICATES OR TRANSCRIPTS)

You are required to have 10 CE hours in order to renew your license. The CE must have been obtained in the year in which your current license was issued. For example, if your license was issued on 2/1/2020, your CE must have been obtained between 2/1/2020 and 1/31/2021.

Continuing education must align with the laboratory duties or aspects of patient care you perform. Broad areas include clinical laboratory practice, legal aspects of healthcare, safety/CPR, or healthcare management. Permitted types of continuing education includes, but is not limited to, training courses, workshops, webinars, relevant college coursework^, published papers/books, and presentation of a lecture or training session.

^ College coursework must have been completed for credit, either as a standalone course or as required for a degree.

Applicant Name _____ License Number_____

Course/Topic	Type of CE	Location/Sponsor	CE hours	Date

If more space is needed, please use multiple copies of this form or include a list in your application packet.

By providing my signature, I hereby verify that the information on this page is accurate.

Signee Printed Name _____ Signature _____

Signee Title _____ Date _____

LABORATORY TRAINING VERIFICATION (TRAINEE APPLICANTS ONLY)

To be completed by the applicant:

□ I am employed by a laboratory which holds a nonwaived CLIA certificate, and I am submitting documentation that I have completed the trainee period of one year and have obtained the training necessary to safely and accurately complete the laboratory testing for which I was trained.

□ I agree that I will not perform any testing for which I have not been trained until I receive the proper training.

□ I attest that I have received at least three months of training in each department in which I will perform **high** complexity testing.

Applicant Printed Name _____ Signature _____

Date _____

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

I hereby verify that the applicant has received the appropriate training to provide him/her the following skills with respect to each specific test he/she performs (list all on page 6), and has been deemed competent in all testing processes, 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 the trainee has had a minimum of 3 months of training or experience for each specialty in which **high** complexity testing is performed, per federal CLIA regulations

Name of Laboratory/Educational Program _____

CLIA Number _____ Certificate Type: □Compliance □Accreditation □PPMP

Signee Printed Name _____ Signature _____

Signee Title _____ Date _____

LABORATORY TRAINING VERIFICATION (POCT APPLICANTS ONLY)

To be completed by the applicant:

□ I am employed by a laboratory which holds a nonwaived CLIA certificate, and I am submitting documentation that I have successfully obtained the training necessary to safely and accurately complete the laboratory testing for which I was trained.

□ I agree that I will not perform any 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 has received the appropriate training to provide him/her the following skills with respect to each specific test he/she performs (list all on page 6), and has been deemed competent in all testing processes, 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

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 AND 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 □moderate ☑high**
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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.