STATE OF NEBRASKA – ONLY FOR LABORATORIES LOCATED IN NEBRASKA

NEBRASKA CLIA CHANGE FORM ***(Complete Only the Applicable Area)***

CLIA NUMBER_____ DATE_____

Laboratory Name_____

Laboratories are to make notification within 30 days of the following changes:

1. **OWNERSHIP**

   New Owner _____

   Effective Date_____ FTIN Number_____

   *****Need to also complete CLIA Ownership Information Form*****

2. **NAME**

   New Name of Facility_____

   (***As you want it to appear on CLIA Certificate)***

   Legal Name of Facility_____

   Effective Date_____

3. **LOCATION**

   New Physical Address_____

   New Mailing Address_____

   Phone/Fax Number Change? New Numbers_____

4. **DIRECTOR (Certificate of Compliance and PPM – CMS-116 Form required).**

   New Director Name_____

   Effective Date_____

5. **APPLICATION TYPE CHANGE (Compliance, PPM and Accreditation – CMS-116 Form required).**

   Currently certified as: ☐ Compliance ☐ Waiver ☐ Accreditation ☐ PPM
   Proposed certified as: ☐ Compliance ☐ Waiver ☐ Accreditation ☐ PPM

   Effective Date for the above application type change:

   If changing to Accreditation certificate please indicate the accrediting agency:
   ☐ **JCAHO** ☐ **COLA** ☐ **AABB** ☐ **CAP** ☐ **ASC** ☐ **AOA** ☐ **ASHI**
   Other (specify)

****NOTE*** ***If changing certificate type to an accreditation certificate, attach documentation from the accrediting agency that you are enrolled.***

For application type changes, please complete the back side of this sheet, indicating the tests that are being performed and the volumes for each test.

6. **LABORATORY CLOSED** Effective Date:_____

LABORATORY DIRECTOR SIGNATURE VALIDATING CHANGES:_____
(Laboratory Director Signature)

PLEASE RETURN THIS FORM TO: **SUZETTE MOELLER, STAFF ASSISTANT**
OFFICE OF ACUTE CARE FACILITIES
DIVISION OF PUBLIC HEALTH – LICENSURE UNIT
PO BOX 94986
LINCOLN, NE 68509-4986

FOR DEPARTMENT USE ONLY: LICENSURE UNIT/LABS 12/07
Changes made for: Ownership _____ Name _____ Location _____
Closed _____ Director _____ App. Type change _____
Date made _____ Changes made by _____ ACO

LIST OF TESTS PERFORMED
(including Waived and PPM)

LAB NAME _____

ADDRESS _____ CITY/ZIP _____

CLIA NO. _____ CERTIFICATE TYPE* _____

NEW APPLICANTS – PLEASE READ: Please list the manufacturer's name and model of the instrument or manufacturer's name of the test kit used for patient testing. For example, do not list "Hematology machine or Strep Kit". This will ensure that you will receive the correct certificate based on the tests performed in your laboratory.

TEST	METHOD	SPECIALTY/SUBSPECIALTY	ANNUAL VOLUME
EXAMPLE: **POTASSIUM**	**KODAK DT60**	**CHEMISTRY**	**50**

*Types of Certificates are: Certificate of Compliance, Certificate of Accreditation, Certificate of Provider-Performed Microscopy, Certificate of Waiver.

SIGNATURE _____ DATE _____

LABCERT 1/00