STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
MEDICAL LABORATORY BOARD
METRO CENTER COMPLEX
665 MAINSTREAM DR. 2nd FLOOR
NASHVILLE, TN 37243
(615) 532-3202
1-800-778-4123 Ext.5325128
tennessee.gov/health

APPLICATION

FOR

A CERTIFICATE TO OPERATE

A MEDICAL LABORATORY TRAINING PROGRAM

FOR MEDICAL LABORATORY PERSONNEL

TYPE OF APPLICATION

( ) Initial $200 ( ) Renewal $100

REG. FEE $ 5.00

Application should be typed or legibly printed in ink.

Enclose the appropriate fee with this application. DO NOT MAIL CASH. Make check or postal money order payable to the State of Tennessee. Journal vouchers must be sent to this office.

MAIL THE ORIGINAL DOCUMENT

KEEP A COPY FOR YOUR RECORDS

Health Related Boards
Medical Laboratory Board
Metro Center Complex
665 Mainstream Dr. 2nd Floor
Nashville, TN 37243

5030)	001 Initial Fee	$ 200.00
5030)	002.Renewal Fee	$ 100.00
5030)	006. Reg. Fee	$ 5.00

Application for Training Program Certification
Medical Laboratory Personnel

Renewal ( ) Initial ( ) Date _____

Name of School _____

Address _____

_____ Zip Code _____

Telephone Number _____

Technician ( )
Junior College ( )
Technologist ( )
General ( )
Specialty ( )
_____
Specify

Type of Ownership:

Individual ( ) Partnership ( ) Corporation ( )

_____

Owner, Partner(s) or Officers(s) Name(s):

_____

Owner's Address:

_____

If more than one owner, partner or officer list name and address on separate sheet.

Medical Director _____

Address _____

Degree Held M.D. ( ) Ph.D. ( ) MA/MS ( )

Indicate Board Certification _____

Program Director _____

Address _____

Education Coordinator _____

Address _____

Degree Held BS/BA ( ) MS/MA ( )

Full Time ( ) Part Time ( )

Teaching Supervisor/Clinical Coordinator

Name _____

Address _____

Degree Held BS/BA ( ) MS/MA ( )

Full Time ( ) Part Time ( )

FACULTY

NAME	DEGREE	TN STATE LIC. CATEGORY AND #	COURSES TAUGHT

Hospitals Providing Clinical Experience
(Attach copies of Contracts)

NAME	ADDRESS	BED SIZE	ANNUAL TEST VOL

Student Capacity per Class _____

Student Capacity per Year _____

Month Class Begins _____

Month Class Graduates _____

Total Enrollment _____

Is this program approved by a National Accrediting Agency? Yes ( ) No ( )

If yes, name of accrediting agency _____

_____

Do you have a student laboratory? Yes ( ) No ( )

Have you enclose the Training Program Self Assessment, Program Evaluation for the current year? Yes ( ) No ( )

Please note the following special requirements for application according to the Department of Health Rules for Training Programs, Medical Laboratory Personnel, Chapter 1200-6-2:

1200-6-2-.01

(c) The Department shall be notified immediately of any changes made in the operation of the school such as a change of ownership, directorship, and/or instructors. A new application for approval must be made in the event there is a change in either ownership or directorship of the training program. A change in ownership shall also include an exchange of stock in an incorporated school.

(d)

Initial training program application fee	$200
Annual Registration (Renewal)	$100
State Regulatory Fee	$ 5

1200-6-2.01(4)(b)

5. Trainee applications shall be submitted for each student prior to the beginning of the approved clinical laboratory experience (practicum). The Department will then issue a temporary trainee permit to the applicant provided he/she is an approved facility. No student shall perform laboratory tests without a valid trainee permit.

1200-6-2-.12

(2) The program shall submit to the Department a complete list of all students that successfully complete their training. This information shall become a part of the students' application for a license. The following information shall be included in the list:

(a) Full name (maiden name if married)
(b) Complete address of the student
(c) Marital status
(d) Date training began
(e) Date training completed
(f) Level of training

AFFIDAVIT

STATE OF _____

COUNTY OF _____

_____, being duly sworn, says that he/she is the person referred to in the foregoing application; that the statements contained therein are true and correct to the best of his/her knowledge and belief; and that he/she has read and understands this affidavit.

_____
Signature

Subscribed and sworn to before me this _____ day of _____, 20___.

_____
Notary Public in and for said County and State

_____
My Commission Expires