APPLICATION
FOR
A CERTIFICATE TO OPERATE
A MEDICAL LABORATORY TRAINING PROGRAM
FOR MEDICAL LABORATORY PERSONNEL

TYPE OF APPLICATION

(       ) Initial   (       ) Renewal
$200       $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
Application for Training Program Certification
Medical Laboratory Personnel

Renewal ( ) Initial ( ) Date ________________

Name of School ______________________________________

Address ______________________________________________

________________________________ Zip Code __________

Telephone Number ______________________________ 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

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Hospitals Providing Clinical Experience  
(Attach copies of Contracts)

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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