



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 DIVISION OF HEALTH LICENSURE AND REGULATION
 OFFICE OF HEALTH RELATED BOARDS
 665 Mainstream Drive
 Nashville, TN 37243
tennessee.gov/health

Office use only:
 Director approval: _____
 Date: _____

TENNESSEE MEDICAL LABORATORY BOARD

Phone: 615-532-5126 Fax: 615-253-8724

WAIVED TESTING NOTIFICATION

1. Clinical Laboratory Imaging Center (HCF) Pharmacy EMS

Name: _____

Address: _____

Contact Person: _____ Telephone: _____

Hours of Operation: _____ Email Address: _____

Clinical laboratory License Number, Health Care Facility License Number (Imaging Center), or Pharmacy License

Number: _____ License Expiration Date: _____

(You must include a copy of current Tennessee facility license)

CLIA Number: _____

2. Test(s) to be Performed (include test name and methodology):

3. Professional Classification(s) of Persons Performing Tests:

4. Location where testing will be performed:

5. Medical Laboratory Director or Physician Responsible for Testing:

Name: _____

Address: _____

Telephone Number: _____

Tennessee Medical License Number: _____

License Expiration Date: _____

(You must include a copy of the supervising physician's current Tennessee medical license)

I affirm that as Medical Director or other physician, I am legally responsible for the clinical laboratory testing procedures listed in this notification I am familiar with all Tennessee state laws and rules applicable to waived laboratory testing including personnel and supervisory requirements, and necessary training, quality control and record keeping requirements.

_____ M.D.

Keep a copy of document for your records.

Date: _____