

APPLICATION/RENEWAL FOR A LICENCE TO OPERATE A MEDICAL LABORATORY

All sections of the application form are required to be completed prior to submission to the Ministry

New Application _____ Date of Application/Renewal: ____/____/____
 Renewal _____ Licence # _____ MM DD YEAR

Laboratory Facility

Name of Facility _____ Telephone # _____
 Street Address _____ Fax # _____
 City _____ Postal Code _____ Email _____

Mailing Address (if different than above) _____
 City _____ Postal Code _____

Type of Licensee

Individual	Corporation	Partnership
Health Authority	Provincial Government	Canadian Blood Services
Hospital	Other (please specify) _____	

Licensee Information

Name _____ Telephone # _____
 Mailing Address _____ Fax # _____
 City _____ Postal Code _____ Email _____

If partnership or corporation - partners or directors:

Name _____ Title or Position _____
 Mailing Address _____ Telephone # _____
 City _____ Postal Code _____ Email _____

Name _____ Title or Position _____
 Mailing Address _____ Telephone # _____
 City _____ Postal Code _____ Email _____

Name _____ Title or Position _____
 Mailing Address _____ Telephone # _____
 City _____ Postal Code _____ Email _____

Ownership of Facility Premises

Does the Licensee own the premises? Yes No

If Licensee **does not** own the laboratory premises:

Lease expiry date: ____ / ____ / ____
 MM DD YEAR

Premises Owner's:

Name _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____ Postal Code _____ Email _____

Qualified Professional: (See Appendix A)

Name _____

Professional Qualification _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____ Postal Code _____ Email _____

Main Laboratory Contact:

Name _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____ Postal Code _____ Email _____

Signatures:

I/We, in applying for a licence to operate a medical laboratory, state that the information and data contained herein is correct.

I/We hereby authorize the Ministry of Health and the Accreditation Program to share, one with the other, any information possessed by the Ministry or the Program in relation to my/our provision of medical services in the past and future.

Signature	Name & Title (please print)	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Updated April 2018

IMPORTANT:

1. Complete the attached List of Tests.
2. Complete the attached List of Staff.

Licence # _____

List of Tests

Name of Test

Updated April 2018

Licence # _____

List of Staff

Last Name	First Name	Employment Start (MM/DD/YEAR)	Position Location in laboratory/clinic	Designation Professional Qualification	Cert. Year Professional Qualification Year	Educational Upgrades