



**NONDIAGNOSTIC GENERAL HEALTH ASSESSMENT APPLICATION (NGHA)**

This registration form must be completed and received by the Santa Clara County Public Health Laboratory *at least 30 days* prior to operation of a program of nondiagnostic general health assessment (NGHA).

Applications that are incomplete and/or failure to submit all required documents may result in delays in the processing of your application.

**PART 1: ADMINISTRATION**

**A. Name of Organization or Operator:** \_\_\_\_\_

Permanent Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip Code

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

CLIA #: \_\_\_\_\_ Exp.: \_\_\_\_\_

**B. Name of Owner:** \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip Code

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**C. Supervisory Committee Members:**

**Name of Physician:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip Code

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

CA Medical License #: \_\_\_\_\_ Exp.: \_\_\_\_\_

**Name of Clinical Laboratory Scientist:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip Code

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

CA Clinical Laboratory Scientist License #: \_\_\_\_\_ Exp.: \_\_\_\_\_

**D. Record Storage:**

All operators must have a permanent address where records of testing and protocols shall be stored for the purpose of review for at least one year after testing has been completed. The Public Health laboratory must be notified in writing within 30 days of any change in record storage.

**Record Storage Address:** \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip Code

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**Part 2: ASSESSMENT PROGRAM**

**A. Location where assessment is to be performed (complete a separate Supplemental Form 2A for each additional location):**

Name of Location: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City

Zip Code

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**B. Dates and hours program will be in operation at this location (attach additional sheets if necessary):**

Dates	Hours	Dates	Hours

Note: Any changes in times, dates or location must be reported in writing to the NGHA program office at least 24 hours prior to the operation of the program.

**C. Nondiagnostic test being conducted at this location:**

( <input checked="" type="checkbox"/> )	Test	Equipment Name	Manufacturer
<input type="checkbox"/>	Total Cholesterol		
<input type="checkbox"/>	High Density Lipoprotein (HDL)		
<input type="checkbox"/>	Triglycerides		
<input type="checkbox"/>	Blood Glucose		
<input type="checkbox"/>	Hemoglobin		
<input type="checkbox"/>	Dipstick Urinalysis		
<input type="checkbox"/>	Fecal Occult Blood		
<input type="checkbox"/>	Urine Pregnancy		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

**D. List all employees for this location (attach additional sheets if necessary):**

Name	Title	( <input checked="" type="checkbox"/> ) Authorized to perform skin puncture	
		Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Note: Submit documentation of authorization to perform skin puncture for each individual checked "Yes" above.

**For Official Use Only:**

Approved /Not Approved: \_\_\_\_\_  
 Fee Received: \_\_\_\_\_

Date License Issued: \_\_\_\_\_  
 Date Fee Submitted: \_\_\_\_\_

License No.: \_\_\_\_\_  
 Check No.: \_\_\_\_\_

**PART 3: COMPLIANCE**

A. This assessment program must be operated per Section 1244 of the California Business and Professions Code. Please answer each of the following questions. To comply with current California law, you must be able to answer yes to all questions and supportive documentation must be submitted with this application.

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | This program will be a nondiagnostic health assessment program (NGHA), whose purpose will be to refer individuals to licensed sources of care as indicated.   |
| <input type="checkbox"/> | <input type="checkbox"/> | This program will utilize only those devices, which comply with all of the following: <ul style="list-style-type: none"><li>A. Meet applicable state and federal performance standards pursuant to Section 26605 of the Health and Safety Code.</li><li>B. Are not adulterated as specified in Article 2 (commencing with Section 26610) of Chapter 6 of Division 21 of the Health and Safety Code.</li><li>C. Are not misbranded as specified in Article 3 (commencing with Section 26630) of Chapter 6 of Division 21 of the Health and Safety Code.</li><li>D. Are not new devices unless they meet the requirements of Section 26670 of the Health and Safety Code.</li></ul> |
| <input type="checkbox"/> | <input type="checkbox"/> | This program maintains a supervisory committee consisting of at a minimum, a California licensed physician and surgeon and a Laboratory Clinical Scientist licensed pursuant to the California Business and Professions Code.   |
| <input type="checkbox"/> | <input type="checkbox"/> | The supervisory committee for the program has adopted written protocols, which shall be followed in the program. (Include a copy of your written protocols with this application.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | The protocols contain provisions of written information to individuals to be assessed. (Include a copy of all written information that will be provided to individuals as part of this program.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Written information to individuals includes the potential risks and benefits of assessment procedures to be performed in the program.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Written information includes the limitations, including the nondiagnostic nature, of assessment examinations of biological specimens performed in the program.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Written information includes information regarding the risk factors or markers targeted by the program.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Written information includes the need for follow up with licensed sources of care for confirmation, diagnosis, and treatment as appropriate.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Written protocols contain the proper use of each devices utilized in the program. Protocols must include the operation of analyzers, maintenance of equipment and supplies, and performance of quality control procedures including the determination of both accuracy and reproducibility of measurements in accordance with instructions provided by the manufacturer of the assessment device used.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Written protocols contain the proper procedures to be employed when drawing blood, if blood specimens are to be obtained.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Written protocols contain procedures to be employed in handling and disposing of all biological specimens to be obtained and material contaminated by biological specimens.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Written protocols contain proper procedures to be employed in response to fainting, excessive bleeding, or other medical emergencies.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Written protocols contain procedures for reporting of assessment results to the individual being assessed (please attach a copy of your report form).   |
| <input type="checkbox"/> | <input type="checkbox"/> | Written protocols contain procedures for referral and follow up to licensed sources of care as indicated.   |
| <input type="checkbox"/> | <input type="checkbox"/> | The written protocols adopted by the supervisory committee shall be maintained for at least one year following completion of the assessment program during which period, they shall be subject to review by the county health officer or designee.  |

B. If a skin puncture to obtain a blood specimen is to be performed:

YES NO

[ ] [ ] The individual performing skin punctures shall be authorized to do via (a) their professional scope of practice or (b) meet California phlebotomy regulations as identified in the California Business and Professions Code, Sections 1242.5, 1246, and 1282.2; California Code of Regulations, Title 17, Sections 1029.31–1029.35, 1031.4, 1031.5, and 1034; and Health and Safety Code, Section 120580 and possess a current phlebotomy license issued by the CA Dept. of Public Health, Laboratory Field Services Program. (Documentation must be submitted with this application.)

[ ] [ ] It is understood that “skin puncture” as related to this program means the collection of a blood specimen by the finger stick method only and does not include venipuncture, arterial puncture, or any other procedure for obtaining a blood specimens.

**PART 4: FEES (LICENSE VALID 7/01/2021 – 6/30/2022)**

- Annual fee: \$175
- Additional Site/day: \$30
- Additional Nondiagnostic Tests: \$30

**Make Checks Payable To:** Santa Clara County Public Health Laboratory

**Return Application To:** Santa Clara County Public Health Laboratory  
NGHA Program  
2220 Moorpark Ave, 2<sup>nd</sup> Floor  
San Jose, CA 95128

**PART 5: LICENSE**

The original license for the specific location address must be posted during operation of a nondiagnostic general health assessment program.

**Name of Person Requesting License:** \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

Business Phone: ( ) \_\_\_\_\_ City \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Zip Code \_\_\_\_\_

I certify that the above information is accurate and complete and that I am aware of the laws and regulations that apply to nondiagnostic testing in the State of California and in the County of Santa Clara in which testing is to be performed.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date of Application

**FOR OFFICIAL USE ONLY**

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

License No.: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Fees Received: \_\_\_\_\_

Date Received: \_\_\_\_\_