

## CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION FOR CERTIFICATION

**ALL APPLICABLE SECTIONS OF THIS FORM MUST BE COMPLETED.**

### I. GENERAL INFORMATION

<input type="checkbox"/> Initial Application      Anticipated Start Date _____ <input type="checkbox"/> Survey <input type="checkbox"/> Change in Certificate Type <input type="checkbox"/> Other Changes (Specify) _____ Effective Date _____	CLIA IDENTIFICATION NUMBER  _____ D _____  (If an initial application leave blank, a number will be assigned)
FACILITY NAME	FEDERAL TAX IDENTIFICATION NUMBER
EMAIL ADDRESS	TELEPHONE NO. (Include area code)      FAX NO. (Include area code)
<input type="checkbox"/> RECEIVE FUTURE NOTIFICATIONS VIA EMAIL	
FACILITY ADDRESS — <i>Physical Location of Laboratory (Building, Floor, Suite if applicable.) Fee Coupon/Certificate will be mailed to this Address unless mailing or corporate address is specified</i>	MAILING/BILLING ADDRESS (If different from facility address) send Fee Coupon or certificate
NUMBER, STREET (No P.O. Boxes)	NUMBER, STREET
CITY      STATE      ZIP CODE	CITY      STATE      ZIP CODE
SEND FEE COUPON TO THIS ADDRESS PICK ONE: <input type="checkbox"/> Physical <input type="checkbox"/> Mailing <input type="checkbox"/> Corporate	SEND CERTIFICATE TO THIS ADDRESS PICK ONE: <input type="checkbox"/> Physical <input type="checkbox"/> Mailing <input type="checkbox"/> Corporate
NAME OF DIRECTOR (Last, First, Middle Initial)	CORPORATE ADDRESS (If different from facility) send Fee Coupon or certificate  NUMBER, STREET  CITY      STATE      ZIP CODE
LABORATORY DIRECTOR'S PHONE NUMBER	Laboratory Director's Phone Number
CREDENTIALS	FOR OFFICE USE ONLY Date Received

### II. TYPE OF CERTIFICATE REQUESTED (Check only one) Please refer to the accompanying instructions for inspection and certificate testing requirements)

- Certificate of Waiver (Complete Sections I – VI and IX – X)
- NOTE: Laboratory directors performing non-waived testing (including PPM) must meet specific education, training and experience under subpart M of the CLIA regulations. Proof of these qualifications for the laboratory director must be submitted with this application.**
- Certificate for Provider Performed Microscopy Procedures (PPM) (Complete Sections I-VII and IX-X)
- Certificate of Compliance (Complete Sections I – X)
- Certificate of Accreditation (Complete Sections I – X) and indicate which of the following organization(s) your laboratory is accredited by for CLIA purposes, or for which you have applied for accreditation for CLIA purposes.
- The Joint Commission       AAHHS/HFAP       AABB       A2LA  
 CAP       COLA       ASHI

**If you are applying for a Certificate of Accreditation, you must provide evidence of accreditation for your laboratory by an approved accreditation organization as listed above for CLIA purposes or evidence of application for such accreditation within 11 months after receipt of your Certificate of Registration.**

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0581. Expiration Date: 03/31/2024. The time required to complete this information collection is estimated to average one hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*\*\*CMS Disclaimer\*\*\*\*\*Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact [LabExcellence@cms.hhs.gov](mailto:LabExcellence@cms.hhs.gov).

**III. TYPE OF LABORATORY** (Check the one most descriptive of facility type)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> 01 Ambulance                                      | <input type="checkbox"/> 11 Health Main. Organization   | <input type="checkbox"/> 22 Practitioner Other (Specify)                  |
| <input type="checkbox"/> 02 Ambulatory Surgery Center                      | <input type="checkbox"/> 12 Home Health Agency  |   |
| <input type="checkbox"/> 03 Ancillary Testing Site in Health Care Facility | <input type="checkbox"/> 13 Hospice   | <input type="checkbox"/> 23 Prison  |
| <input type="checkbox"/> 04 Assisted Living Facility                       | <input type="checkbox"/> 14 Hospital  | <input type="checkbox"/> 24 Public Health Laboratories                    |
| <input type="checkbox"/> 05 Blood Bank                                     | <input type="checkbox"/> 15 Independent   | <input type="checkbox"/> 25 Rural Health Clinic                           |
| <input type="checkbox"/> 06 Community Clinic                               | <input type="checkbox"/> 16 Industrial  | <input type="checkbox"/> 26 School/Student Health Service                 |
| <input type="checkbox"/> 07 Comp. Outpatient Rehab Facility                | <input type="checkbox"/> 17 Insurance   | <input type="checkbox"/> 27 Skilled Nursing Facility/<br>Nursing Facility |
| <input type="checkbox"/> 08 End Stage Renal Disease Dialysis Facility      | <input type="checkbox"/> 18 Intermediate Care Facilities for Individuals with Intellectual Disabilities | <input type="checkbox"/> 28 Tissue Bank/Repositories                      |
| <input type="checkbox"/> 09 Federally Qualified Health Center              | <input type="checkbox"/> 19 Mobile Laboratory   | <input type="checkbox"/> 29 Other (Specify)                               |
| <input type="checkbox"/> 10 Health Fair                                    | <input type="checkbox"/> 20 Pharmacy  |   |
|  | <input type="checkbox"/> 21 Physician Office  |   |

**IV. HOURS OF LABORATORY TESTING** (List times during which laboratory testing is performed in HH:MM format) If testing 24/7 Check Here

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

(For multiple sites, attach the additional information using the same format.)

**V. MULTIPLE SITES** (must meet one of the regulatory exceptions to apply for this provision in 1-3 below)

**Are you applying for a single site CLIA certificate to cover multiple testing locations?**

- No. If no, go to section VI.       Yes. If yes, complete remainder of this section.

**Indicate which of the following regulatory exceptions applies to your facility's operation.**

- Is this a laboratory that is not at a fixed location, that is, a laboratory that moves from testing site to testing site, such as mobile unit providing laboratory testing, health screening fairs, or other temporary testing locations, and may be covered under the certificate of the designated primary site or home base, using its address?
 

Yes    No

If yes and a mobile unit is providing the laboratory testing, record the vehicle identification number(s) (VINs) and attach to the application.
- Is this a not-for-profit or Federal, State or local government laboratory engaged in limited (not more than a combination of 15 moderate complexity or waived tests per certificate) public health testing and filing for a single certificate for multiple sites?
 

Yes    No

If yes, provide the number of sites under the certificate \_\_\_\_\_ and list name, address and test performed for each site below.
- Is this a hospital with several laboratories located at contiguous buildings on the same campus within the same physical location or street address and under common direction that is filing for a single certificate for these locations?
 

Yes    No

If yes, provide the number of sites under this certificate \_\_\_\_\_ and list name or department, location within hospital and specialty/subspecialty areas performed at each site below.

**If additional space is needed, check here  and attach the additional information using the same format.**

NAME AND ADDRESS/LOCATION		TESTS PERFORMED/SPECIALTY/SUBSPECIALTY
NAME OF LABORATORY OR HOSPITAL DEPARTMENT		
ADDRESS/LOCATION (Number, Street, Location if applicable)		
CITY, STATE, ZIP CODE	TELEPHONE NO. (Include area code)	
NAME OF LABORATORY OR HOSPITAL DEPARTMENT		
ADDRESS/LOCATION (Number, Street, Location if applicable)		
CITY, STATE, ZIP CODE	TELEPHONE NO. (Include area code)	

In the next three sections, indicate testing performed and estimated annual test volume.

**VI. WAIVED TESTING** *If only applying for a Certificate of Waiver, complete this section and skip sections VII (PPM Testing) and VIII (Non-Waived Testing).*

Identify the waived testing (to be) performed by completing the table below. Include each analyte, test system, or device used in the laboratory.

ANALYTE / TEST	TEST NAME	MANUFACTURER
Example: Streptococcus group A	Ace Rapid Strep Test	Acme Corporation

Indicate the **ESTIMATED TOTAL ANNUAL TEST** volume for all waived tests performed \_\_\_\_\_

Check if no waived tests are performed

If additional space is needed, check here  and attach additional information using the same format.

**VII. PPM TESTING** *If only applying for a Certificate for PPM, complete this section and skip section VIII (Non-Waived Testing).*

Listed below are the **only** PPM tests that can be performed by a facility having a Certificate for PPM. Mark the checkbox by each PPM procedure(s) to be performed.

- Direct wet mount preparations for the presence or absence of bacteria, fungi, parasites, and human cellular elements
- Potassium hydroxide (KOH) preparations
- Pinworm examinations
- Fern tests
- Post-coital direct, qualitative examinations of vaginal or cervical mucous
- Urine sediment examinations
- Nasal smears for granulocytes
- Fecal leukocyte examinations
- Qualitative semen analysis (limited to the presence or absence of sperm and detection of motility)

Indicate the **ESTIMATED TOTAL ANNUAL TEST** volume for all PPM tests performed \_\_\_\_\_

If also performing waived complexity tests, complete Section VI. For laboratories applying for certificate of compliance or certificate of accreditation, also include PPM test volume in the specialty/subspecialty category and the "total estimated annual test volume" in section VIII.

Check if no PPM tests are performed

If additional space is needed, check here  and attach additional information using the same format.

**VIII. NON-WAIVED TESTING** (Including PPM testing if applying for a Certificate of Compliance or Certificate of Accreditation) Complete this section only if you are applying for a Certificate of Compliance or a Certificate of Accreditation.

Identify the non-waived testing (to be) performed by completing the table below. Be as specific as possible. This includes each analyte test system or device used in the laboratory. Use (M) for moderate complexity and (H) for high complexity.

ANALYTE / TEST	TEST NAME	MANUFACTURER	M or H
Example: Potassium	Quick Potassium Test	Acme Lab Corporation	M

If additional space is needed, check here  and attach additional information using the same format.

If you perform testing other than or in addition to waived tests, complete the information below. If applying for one certificate for multiple sites, the total volume should include testing for ALL sites.

If additional space is needed, check here and attach additional information using the same format." Include text box similar to Section VII.

Place a check (✓) in the box preceding each specialty/subspecialty in which the laboratory performs testing. Enter the estimated annual test volume for each specialty. Do not include testing not subject to CLIA, waived tests, or tests run for quality control, calculations, quality assurance or proficiency testing when calculating test volume. (For additional guidance on counting test volume, see the instructions included with the application package.)

If applying for a Certificate of Accreditation, indicate the name of the Accreditation Organization beside the applicable specialty/subspecialty for which you are accredited for CLIA compliance. (The Joint Commission, AAHHS/HFAP, AABB, A2LA ,CAP, COLA or ASHI)

SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME	SPECIALTY / SUBSPECIALTY	ACCREDITING ORGANIZATION	ANNUAL TEST VOLUME
<b>HISTOCOMPATIBILITY 010</b>			<b>HEMATOLOGY 400</b>		
<input type="checkbox"/> Transplant			<input type="checkbox"/> Hematology		
<input type="checkbox"/> Nontransplant			<b>IMMUNOHEMATOLOGY</b>		
<b>MICROBIOLOGY</b>			<input type="checkbox"/> ABO Group & Rh Group 510		
<input type="checkbox"/> Bacteriology 110			<input type="checkbox"/> Antibody Detection (transfusion) 520		
<input type="checkbox"/> Mycobacteriology 115			<input type="checkbox"/> Antibody Detection (nontransfusion) 530		
<input type="checkbox"/> Mycology 120			<input type="checkbox"/> Antibody Identification 540		
<input type="checkbox"/> Parasitology 130			<input type="checkbox"/> Compatibility Testing 550		
<input type="checkbox"/> Virology 140			<b>PATHOLOGY</b>		
<b>DIAGNOSTIC IMMUNOLOGY</b>			<input type="checkbox"/> Histopathology 610		
<input type="checkbox"/> Syphilis Serology 210			<input type="checkbox"/> Oral Pathology 620		
<input type="checkbox"/> General Immunology 220			<input type="checkbox"/> Cytology 630		
<b>CHEMISTRY</b>			<b>RADIOBIOASSAY 800</b>		
<input type="checkbox"/> Routine 310			<input type="checkbox"/> Radiobioassay		
<input type="checkbox"/> Urinalysis 320			<b>CLINICAL CYTOGENETICS 900</b>		
<input type="checkbox"/> Endocrinology 330			<input type="checkbox"/> Clinical Cytogenetics		
<input type="checkbox"/> Toxicology 340			<b>TOTAL ESTIMATED ANNUAL TEST VOLUME:</b>		

**IX. TYPE OF CONTROL (CHECK THE ONE MOST DESCRIPTIVE OF OWNERSHIP TYPE)**

<p><b>VOLUNTARY NONPROFIT</b></p> <p><input type="checkbox"/> 01 Religious Affiliation</p> <p><input type="checkbox"/> 02 Private Nonprofit</p> <p><input type="checkbox"/> 03 Other Nonprofit</p> <p>_____</p> <p><i>(Specify)</i></p>	<p><b>FOR PROFIT</b></p> <p><input type="checkbox"/> 04 Proprietary</p>	<p><b>GOVERNMENT</b></p> <p><input type="checkbox"/> 05 City</p> <p><input type="checkbox"/> 06 County</p> <p><input type="checkbox"/> 07 State</p> <p><input type="checkbox"/> 08 Federal</p> <p><input type="checkbox"/> 09 Other Government</p> <p>_____</p> <p><i>(If 09 is selected, please specify the country or the province.)</i></p>
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Does this facility have partial or full ownership by a foreign entity or foreign government?

Yes  No

If Yes, what is the country of origin for the foreign entity? \_\_\_\_\_

**X. DIRECTOR AFFILIATION WITH OTHER LABORATORIES**

If the director of this laboratory serves as director for additional laboratories that are separately certified, please complete the following:

CLIA NUMBER	NAME OF LABORATORY

**ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION**

Any person who intentionally violates any requirement of section 353 of the Public Health Service Act as amended or any regulation promulgated thereunder shall be imprisoned for not more than 1 year or fined under title 18, United States Code or both, except that if the conviction is for a second or subsequent violation of such a requirement such person shall be imprisoned for not more than 3 years or fined in accordance with title 18, United States Code or both.

Consent: The applicant hereby agrees that such laboratory identified herein will be operated in accordance with applicable standards found necessary by the Secretary of Health and Human Services to carry out the purposes of section 353 of the Public Health Service Act as amended. The applicant further agrees to permit the Secretary, or any Federal officer or employee duly designated by the Secretary, to inspect the laboratory and its operations and its pertinent records at any reasonable time and to furnish any requested information or materials necessary to determine the laboratory's eligibility or continued eligibility for its certificate or continued compliance with CLIA requirements.

PRINT NAME OF DIRECTOR OF LABORATORY \_\_\_\_\_

PRINT NAME OF OWNER OF LABORATORY \_\_\_\_\_

SIGNATURE OF OWNER/DIRECTOR OF LABORATORY (SIGN IN INK OR USE A SECURE ELECTRONIC SIGNATURE)	DATE
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**NOTE: Completed 116 applications must be sent to your local State Agency. Do not send any payment with your completed 116 application.**

**STATE AGENCY CONTACT INFORMATION CAN BE FOUND AT:**  
<https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>

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# THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION (FORM CMS-116)

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## INSTRUCTIONS FOR COMPLETION

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CLIA requires every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being to meet certain Federal requirements. If your facility performs tests for these purposes, it is considered, under the law, to be a laboratory. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service are not considered laboratories. CLIA does not apply to a facility that only performs forensic testing. CLIA applies even if only one or a few basic tests are performed, and even if you are not charging for testing. In addition, the CLIA legislation requires financing of all regulatory costs through fees assessed to affected facilities.

The CLIA application (Form CMS-116) collects information about your laboratory's operation which is necessary to determine the fees to be assessed, to establish baseline data and to fulfill the statutory requirements for CLIA. This information will also provide an overview of your facility's laboratory operation. All information submitted should be based on your facility's laboratory operation as of the date of form completion.

**NOTE: WAIVED TESTS ARE NOT EXEMPT FROM CLIA. FACILITIES PERFORMING ONLY THOSE TESTS CATEGORIZED AS WAIVED MUST APPLY FOR A CLIA CERTIFICATE OF WAIVER.**

**NOTE: Laboratory directors performing non-waived testing (including PPM) must meet specific education, training and experience under subpart M (42 CFR PART 493) of the CLIA requirements. Proof of these requirements for the laboratory director must be submitted with the application. Information to be submitted with the application include:**

- Verification of State Licensure, as applicable
- Documentation of qualifications:
  - Education (copy of Diploma, transcript from accredited institution, CMEs),
  - Credentials, and
  - Laboratory experience.

Individuals who attended foreign schools must have an evaluation of their credentials determining equivalency of their education to education obtained in the United States. Failure to submit this information will delay the processing of your application.

**ALL APPLICABLE SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED TO THE FACILITY. PRINT LEGIBLY OR TYPE INFORMATION.**

### I. GENERAL INFORMATION

For an initial applicant, check "initial application". For an initial survey or for a recertification, check "survey". For a request to change the type of certificate, check "change in certificate type" and provide the effective

date of the change. For all other changes, including change in location, director, lab closure, etc., check "other changes" and provide the effective date of the change.

**CLIA Identification Number:** For an initial applicant, the CLIA number should be left blank. The number will be assigned when the application is processed. For all other applicants, enter the 10 digit CLIA identification number already assigned and listed on your CLIA certificate.

**Facility Name:** Be specific when indicating the name of your facility, particularly when it is a component of a larger entity, e.g., respiratory therapy department in XYZ Hospital. For a physician's office, this may be the name of the physician. NOTE: the information provided is what will appear on your certificate.

**Email Address:** A valid Email Address is optional and will be used for communications between the CLIA program and the laboratory. Selecting the RECEIVE NOTIFICATIONS VIA EMAIL checkbox, requires the laboratory to enter a valid Email Address.

**Physical Facility Address:** This address is mandatory and must reflect the physical location where the laboratory testing is performed. The address may include a floor, suite and/or room location, but cannot be a Post Office box or Mail Stop.

If the laboratory has a separate mailing and/or corporate address (from the Facility Address), please complete the appropriate sections on the form.

**Mailing Address:** This address is optional and may be used if the laboratory wants to direct the mailing of the CLIA fee coupon and/or CLIA certificate to an alternate location, such as an accounts payable office. A Post Office box number or Mail Stop number may be used as part of the Mailing Address for this section.

**Corporate Address:** This address is optional and may be used if the laboratory wants to direct the mailing of the CLIA fee coupon and/or CLIA certificate to another location, such as, the main headquarters or home office for the laboratory. A Post Office box number or Mail Stop number may be used as part of the Corporate Address for this section.

**Form Mailing:** Select the address (Physical, Mailing, Corporate) where the CLIA fee coupon and CLIA certificate are to be mailed.

**For Office Use Only:** The date received is the date the form is received by the state agency or CMS regional office for processing.

### II. TYPE OF CERTIFICATE REQUESTED

Select your certificate type based on the highest level of test complexity performed by your laboratory. A laboratory performing non-waived tests can choose Certificate of Compliance or Certificate of Accreditation based on the agency you wish to survey your laboratory.

When completing this section, please remember that a facility holding a:

- **Certificate of Waiver** can only perform tests categorized as waived;\*
- **Certificate for Provider Performed Microscopy Procedures (PPM)** can only perform tests categorized as PPM, or tests categorized as PPM and waived tests;\*
- **Certificate of Compliance** can perform tests categorized as waived, PPM and moderate and/or high complexity tests provided the applicable CLIA quality standards are met following a CLIA survey; and
- **Certificate of Accreditation** can perform tests categorized as waived, PPM and moderate and/or high complexity non-waived tests provided the laboratory is currently accredited by an approved accreditation organization. (If your CMS-approved accreditation organization is not listed, contact your local State Agency for further instructions.)

\*A current list of waived and PPM tests may be obtained from your State agency. Specific test system categorizations can also be found on the Internet at: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/clia.cfm>.

### **III. TYPE OF LABORATORY**

Select the type that is most descriptive of the location where the laboratory testing is performed.

If selecting 'mobile laboratory' (code 19), a mobile laboratory is defined as a movable, self-contained operational laboratory with its own personnel, equipment, and records. For record keeping purposes, include, on a separate sheet of paper, the vehicle identification numbers (VINs) of all vehicles used for mobile laboratory testing.

If selecting 'Practitioner Other' (code 22), this type includes practitioners such as, dentists, chiropractors, etc.

### **IV. HOURS OF ROUTINE OPERATION**

Provide only the times when actual laboratory testing is performed in your facility. Please use the HH:MM

format and check box marked '24/7' if laboratory testing is performed continuously, e.g., 24 hours a day, 7 days a week. Do not use military time.

### **V. MULTIPLE SITES**

You can only qualify for the multiple site provision (more than one site under one certificate) if you meet one of the CLIA requirements described in 42 CFR 493.493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3). Hospice and HHA could qualify for an exception.

### **VI. WAIVED TESTING**

Indicate the estimated total annual test volume for all waived tests performed. List can be found at: <https://www.cms.gov/CLIA/downloads/waivetbl.pdf>

### **VII. PPM TESTING**

Indicate the estimated total annual test volume for all PPM tests performed. List can be found at: <https://www.cms.gov/CLIA/downloads/ppmplist.pdf>

### **VIII. NON-WAIVED TESTING (INCLUDING PPM)**

The total Estimated Annual Test volume in this section includes all non-waived testing, including PPM tests previously counted in section VII. Follow the specific instructions on page 3 of the Form CMS-116 when completing this section for test counting information. (Note: The Accrediting Organization column should reflect accreditation information for CLIA purposes only; e.g., CAP, etc.)

### **IX. TYPE OF CONTROL**

Select the type of ownership or control which most appropriately describes your facility.

### **X. DIRECTOR OF ADDITIONAL LABORATORIES**

List all other facilities for which the director is responsible and that are under different certificates. Note that for a Certificate of PPM, Certificate of Compliance or Certificate of Accreditation, an individual can only serve as the director for no more than five certificates.

#### **Reminders - Before submitting the Form CMS-116:**

1. Include the current or estimated annual test volume.
2. For Certificate for PPM, Certificate of Compliance, or Certificate of Accreditation, include the laboratory director qualifications.
3. Do not send any money with your application.
4. Send the completed Form CMS-116 to the appropriate State Agency (<https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>).

Once the completed Form CMS-116 has been returned to the applicable State agency and it is processed, a fee remittance coupon will be issued. The fee remittance coupon will indicate your CLIA identification number and the amount due for the certificate, and if applicable the compliance (survey) or validation fee. If you are applying for a Certificate of Compliance or Certificate of Accreditation, you will initially pay for and receive a Registration Certificate. A Registration Certificate permits a facility requesting a Certificate of Compliance to perform testing until an onsite inspection is conducted to determine program compliance; or for a facility applying for a Certificate of Accreditation, until verification of accreditation by an approved accreditation organization is received by CMS.

If you need additional information concerning CLIA, or if you have questions about completion of this form, please contact your State agency. State agency contact information can be found at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>

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**VIII. NON-WAIVED TESTING**

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**TESTS COMMONLY PERFORMED AND THEIR CORRESPONDING  
LABORATORY SPECIALTIES/SUBSPECIALITIES**

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**HISTOCOMPATIBILITY (010)**

HLA Typing (disease associated antigens)

**MICROBIOLOGY****Bacteriology (110)**

Gram Stain

Culture

Susceptibility

Strep screen

Antigen assays (H.pylori, Chlamydia, etc.)

**Mycobacteriology (115)**

Acid Fast Smear

Mycobacterial culture

Mycobacterial susceptibility

**Mycology (120)**

Fungal Culture

DTM

KOH Preps

**Parasitology (130)**

Direct Preps

Ova and Parasite Preps

Wet Preps

**Virology (140)**

RSV (Not including waived kits)

HPV assay

Cell culture

**DIAGNOSTIC IMMUNOLOGY****Syphilis Serology (210)**

RPR

FTA, MHATP

**General Immunology (220)**

Allergen testing

ANA

Antistreptolysin O

Antigen/Antibody (hepatitis, herpes, rubella, etc.)

Complement (C3, C4)

Immunoglobulin

HIV

Mononucleosis assay

Rheumatoid factor

Tumor marker (AFP, CA 19-9, CA 15-3, CA 125)\*

\*Tumor markers can alternatively be listed under  
Routine Chemistry instead of General Immunology.

**HEMATOLOGY (400)**

Complete Blood Count (CBC)

WBC count

RBC count

Hemoglobin

Hematocrit (Not including spun micro)

Platelet count

Differential

Activated Clotting Time

Prothrombin time (Not including waived instruments)

Partial thromboplastin time

Fibrinogen

Reticulocyte count

Manual WBC by hemocytometer

Manual platelet by hemocytometer

Manual RBC by hemocytometer

Sperm count

**IMMUNOHEMATOLOGY**

ABO group (510)

Rh(D) type (510)

Antibody screening

Antibody identification (540)

Compatibility testing (550)

**PATHOLOGY**

Dermatopathology

Oral Pathology (620)

PAP smear interpretations (630)

Other Cytology tests (630)

Histopathology (610)

**RADIOBIOASSAY (800)**

Red cell volume

Schilling test

**CLINICAL CYTOGENETICS (900)**

Fragile X

Buccal smear

Prader-Willi syndrome

FISH studies for: neoplastic disorders, congenital disorders  
or solid tumors.



## **CHEMISTRY**

### **Routine Chemistry (310)**

Albumin  
Ammonia  
Alk Phos  
ALT/SGPT  
AST/SGOT  
Amylase  
Bilirubin  
Blood gas (pH, pO<sub>2</sub>, pCO<sub>2</sub>)  
BUN  
Calcium  
Chloride  
Cholesterol  
Cholesterol, HDL  
CK/CK isoenzymes  
CO<sub>2</sub>  
Creatinine  
Ferritin  
Folate  
GGT  
Glucose (Not fingerstick)  
Iron  
LDH/LDH isoenzymes  
Magnesium  
Potassium  
Protein, electrophoresis  
Protein, total  
PSA  
Sodium  
Triglycerides  
Troponin  
Uric acid  
Vitamin B12

### **Endocrinology (330)**

Cortisol  
HCG (serum pregnancy test)  
T3  
T3 Uptake  
T4  
T4, free  
TSH

### **Toxicology (340)**

Acetaminophen  
Blood alcohol  
Blood lead (Not waived)  
Carbamazepine  
Digoxin  
Ethosuximide  
Gentamicin  
Lithium  
Phenobarbital  
Phenytoin  
Primidone  
Procainamide  
NAPA  
Quinidine  
Salicylates  
Theophylline  
Tobramycin  
Therapeutic Drug Monitoring

### **Urinalysis\*\* (320)**

Automated Urinalysis (Not including waived instruments)  
Microscopic Urinalysis  
Urine specific gravity by refractometer  
Urine specific gravity by urinometer  
Urine protein by sulfosalicylic acid

\*\* Dipstick urinalysis is counted in Section VI. WAIVED TESTING

**NOTE:** This is not a complete list of tests covered by CLIA. Other non-waived tests and their specialties/ subspecialties can be found at <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/SubjecttoCLIA.pdf> and <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/lccodes.pdf>. You may also call your State agency for further information. State agency contact information can be found at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>.

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## GUIDELINES FOR COUNTING TESTS FOR CLIA

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- For **chemistry**, each non-calculated analyte is counted separately (e.g., Lipid Panel consisting of a total cholesterol, HDL cholesterol, LDL cholesterol and triglycerides equals 4 tests).
- For **clinical cytogenetics**, the number of tests is determined by the number of specimen types processed on each patient; e.g., a bone marrow and a venous blood specimen received on one patient is counted as two tests. NOTE: For all other genetic tests, the number of tests is determined by the number of results reported in the final report.
- For manual gynecologic and nongynecologic **cytology**, each slide (not case) is counted as one test.
- For **flow cytometry**, each measured individual analyte (e.g. T cells, B cells, CD4, etc.) that is ordered and reported should be counted separately.
- For **general immunology**, testing for allergens should be counted as one test per individual allergen.
- **Genetics tests** should be placed in the specialty or subspecialty where they fit best, according to the methodology of the test.
- For **hematology**, each **measured** individual analyte of a **complete blood count** or **flow cytometry** test that is ordered **and reported** is counted separately. The **WBC differential** is counted as one test.
- For **histocompatibility**, each HLA typing (including disease associated antigens) is counted as one test, each HLA antibody screen is counted as one test and each HLA cross match is counted as one test. For example, a B-cell, a T-cell, and an auto-crossmatch between the same donor and recipient pair would be counted as 3 tests.
- For **histopathology**, each block (not slide) is counted as one test. Autopsy services are not included. For those laboratories that perform special stains on histology slides, the test volume is determined by adding the number of special stains performed on slides to the total number of specimen blocks prepared by the laboratory.
- For **immunohematology**, each ABO, Rh, antibody screen, crossmatch or antibody identification is counted as one test.
- For **microbiology**, susceptibility testing is counted as one test per group of antibiotics used to determine sensitivity for one organism. Cultures are counted as one per test request from each specimen regardless of the extent of identification, number of organisms isolated, and number of tests/procedures required for identification. Each gram stain or acid-fast bacteria (AFB) smear requested from the primary source is counted as one. For example, if a sputum specimen has a routine bacteriology culture and gram stain, a mycology test, and an AFB smear and culture ordered, this would be counted as five tests. For parasitology, the direct smear and the concentration and prepared slide are counted as one test.
- For **urinalysis**, microscopic and macroscopic examinations, each count as one test. Macroscopics (dipsticks) are counted as one test regardless of the number of reagent pads on the strip.
- For **all specialties/subspecialties**, do not count calculations (e.g., A/G ratio, MCH, T7, etc.), quality control, quality assurance, or proficiency testing assays.

If you need additional information concerning counting tests for CLIA, please contact your State agency.