# Guide to Match Information on CMS 116 CLIA Form with the California Laboratory Online Licensing System





#### **Online Application**

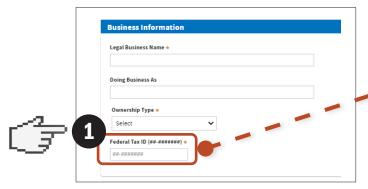
For a renewal of laboratory license online application, refer to the user manual for "Single Site" "Renew License" at

cdph.ca.gov/OnlineAppHelp

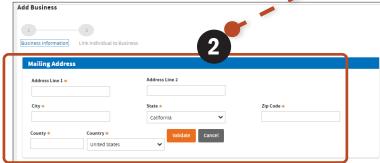
Follow this guide only if you are renewing with changes. Describe the changes on Section I, and enter the "Effective Date."

#### Find the matching number on the right.

1. "Tax ID" online must match the CMS 116 form, page 1.



2. "Mailing Address" must match.



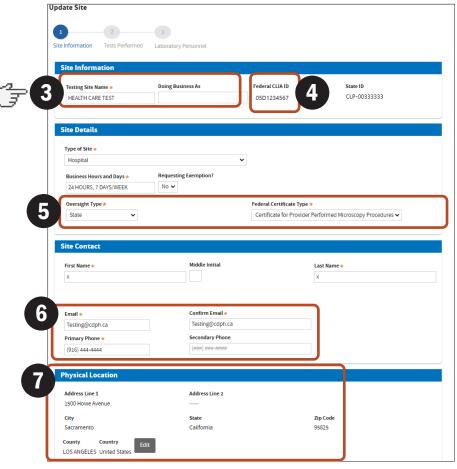
# **CMS 116 form (Page 1)**



CLINIC			OVEMENT AMENDM OR CERTIFICATION	ENTS (CLIA	)		
L CENEDAL INFORMATI	ALL APPL		THIS FORM MUST BE COMPL	ETED.			
I. GENERAL INFORMATI		I Store Dodge	CLIA IDENTIFICATION NUMBER				
Initial Application	Anticipated	Start Date	-				
Survey			D				
Change in Certificate	**		(If an initial application leave blan	k, a number will b	e assigned)		
Other Changes (Specif	y)						
Effective Date FACILITY NAME			FEDERAL TAX IDENTIFICATION NU	MADED			
FACILITY NAME			FEDERAL TAX IDENTIFICATION NO	IVIDEN			
EMAIL ADDRESS			TELEPHONE NO. (Include area code)	FAX NO, (Include	area code)		
		. 7	TELETHONE NO. Include area code)	TACTIO. Include	area code/		
FACILITY ADDRESS — Physical			MAILING/BILLING ADDRESS (If diffe	rent from facility add	ress) send Fee Coun		
applicable.) Fee Couper rtificat or corporate address is specified	te will be mailed	to this Address un	r certificate	, , , , , , , , , , , , , , , , , , , ,	,		
NUMBER, STREET (No P.O. Boxe	es)		JUMBER, STREET				
		7					
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE		
SELIE SEE COURCUITO TURA INC			CODDODATE ADDRESS #4 ##	NUMBER STREET			
SEND FEE COUPON TO THIS ADD	PICK ON		CORPORATE ADDRESS (If different from facility) send Fee Coupon or	NUMBER, STREET			
Physical	Phys		certificate				
Mailing	Mail		CITY	STATE	ZIP CODE		
corporate		orate					
NAME OF DIRECTOR (Last, Firs	t, Middle Initial)		Laboratory Director's Phone Numb	per			
CREDENTIALS			FOR OFFICE USE ONLY				
Cheberrines							
II TYPE OF CERTIFICAT	E RECLIESTI	ED (Chack only one) Plac	Date Received ase refer to the accompanying in	nstructions for in	spection and		
certificate testing requirer		Check only one) Flee	ase refer to the accompanying ii	istructions for in	spection and		
Certificate of Waive	r (Complete	Sections I – VI and IX	( – X)				
			PPM) must meet specific education,	training and expe	ience under		
subpart M of the CLIA regulat	tions. Proof of	these qualifications for the	e laboratory director must be submi	tted with this appl	ication.		
			lures (PPM) (Complete Sectio	ns I-VII and IX-	()		
Certificate of Comp							
			and indicate which of the following indicate which of the following in the for according to the form and indicate the form and indicate the following indicate t				
-			AABB A2LA	reditation for C	LIA purposes.		
The Joint Con	nmission	☐ ACHC	AABB AZLA				
CAP		COLA	ASHI				
accreditation organization as	listed above for		evidence of accreditation for your ce of application for such accreditat				
your Certificate of Registratio PRA Disclosure Statement	11.						
According to the Paperwork Redu			spond to a collection of information unle				
		n collection is 0938-0581. Expira	ation Date: 03/31/2024. The time required t				
	r response, inclu	ding the time to review instruc	tions, search existing data resources, gath	ner the data needed.	and complete and		
estimated to average one hour pe review the information collection.	If you have com	ments concerning the accuracy	tions, search existing data resources, gath of the time estimate(s) or suggestions for 26-05, Baltimore, Maryland 21244-1850.	r improving this form	, please write to:		



Edit the Testing Site or facility information. Update with new information.



- 3. "Testing Site Name" must match with the "Facility Name."
- 4. CLIA ID cannot be edited online. This must match on CMS116. Do not leave blank.
- 5. "Oversight Type" must match with Section II.
- 6. Email and phone must match.
- 7. "Physical Location" and "Facility Address" must match.

# CMS 116 form (Page 1)



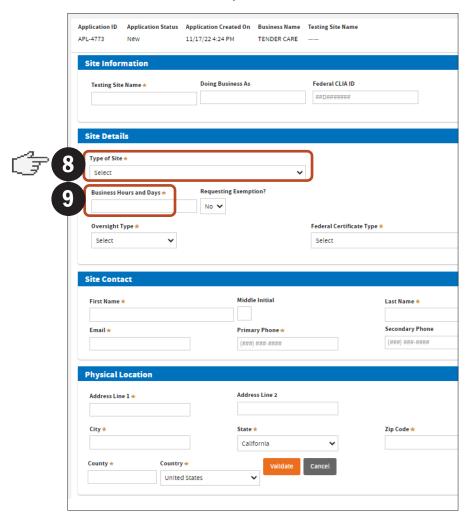
CLINICAL	LABOR	ATORY IMPR	OVEMENT AMENDM	ENTS (CLI	A)
	AP	PLICATION FO	OR CERTIFICATION	•	
AL  I. GENERAL INFORMATION	L APPLICA	BLE SECTIONS OF	THIS FORM MUST BE COMPL	ETED.	
Initial Application Ant	icipated Sta	art Date	CLIA IDENTIFICATION NUMBER		)
Survey		4.	_		
Change in Certificate Type			D		J
Other Changes (Specify)			(If an initial application leave blan	k, a number will	be assigne
Effective Date					
FACILITY NAME			FEDERAL TAX IDENTIFICATION NU	MBER	
EMAIL ADDRESS			TELEPHONE NO. (Include area code)	FAX NO. (Include	e area code
DECEIVE CUTURE MOTIEICATIONS	S VIA EMAII				
FACILITY ADDRESS — Physical Location  applicable.) Fee Coupon/Certificate will to corporate address is specified.			MAILING/BILLING ADDRESS (If different control or certificate	rent from facility ac	ddress) send
NUMBER, STREET (No P.O. Boxes)			NUMBER, STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP COL
SEND FEE COUPON TO THIS ADDRESS	SEND CERTIF	ICATE TO THIS ADDRESS	CORPORATE ADDRESS (If different	NUMBER, STREE	T T
PICK ONE:	PICK ONE:	ICATE TO THIS ADDRESS	from facility) send Fee Coupon or certificate	NOWIDEN, STREET	- '
Physical	Physical				
Mailing	Mailing		CITY	STATE	ZIP COD
Corporate	Corpora	te			
NAME OF DIRECTOR (Last, First, Midd	fle Initial)		Laboratory Director's Phone Numb	er	
CREDENTIALS			FOR OFFICE USE ONLY		
			Date Received		
II TYPE OF CERTIFICATE RE	OLIESTED	(Chack anly ana) Pla	Date Received ase refer to the accompanying in	etructions for i	nenoction
certificate testing requirements		(Check only one) Flea	ise refer to the accompanying in	_	rispection
Certificate of Waiver (Co	mnlete Se	ections I – VI and IX	' – X)	Section	on
	•		PPM) must meet specific education,	training and exp	erience ur
subpart M of the CLIA regulations.	Proof of the	se qualifications for the	laboratory director must be submit	ted with this app	plication.
			lures (PPM) (Complete Section	ns I-VII and IX	-X)
Certificate of Compliance					
			nd indicate which of the follo		
	-		hich you have applied for acc	reultation for	CLIA pu
The Joint Committee	sion	ACHC	AABB A2LA		
The Joint Commiss			ASHI		
CAP		COLA			approved
CAP  If you are applying for a Certificate	of Accredita	ition, you must provide	evidence of accreditation for your	aboratory by an	nthe after
CAP  If you are applying for a Certificate accreditation organization as listed	of Accredita	ition, you must provide		aboratory by an on within 11 mo	nths after
CAP  f you are applying for a Certificate accreditation organization as listed your Certificate of Registration.  PRA Disclosure Statement	of Accredita above for C	ntion, you must provide	evidence of accreditation for your lee of application for such accreditation	on within 11 mo	
CAP  If you are applying for a Certificate accreditation organization as listed your Certificate of Registration.  PRA Disclosure Statement  According to the Paperwork Reduction A	of Accredita above for C	LIA purposes or evident	evidence of accreditation for your lee of application for such accreditation for such accreditation for such accreditation of a collection of information unle	on within 11 mo	I OMB contr
CAP  If you are applying for a Certificate accreditation organization as listed your Certificate of Registration.  PRA Disclosure Statement According to the Paperwork Reduction A fibe valid OMB control number for this in stimated to average one hour per respo	of Accredita above for C	tition, you must provide LIA purposes or evidend persons are required to re lection is 0938-0581. Expira the time to review instruc	evidence of accreditation for your lee of application for such accreditation spond to a collection of information unle tion Date: 03/31/2024. The time required to tions, search existing data resources, gath	on within 11 mo	I OMB contrormation co
CAP  If you are applying for a Certificate accreditation organization as listed your Certificate of Registration.  PRA Disclosure Statement according to the Paperwork Reduction After valid OMB control number for this in stimated to average one hour per responseview the information collection. If you	of Accredita above for C act of 1995, no aformation col onse, including have commen	tition, you must provide LIA purposes or evident persons are required to re- lection is 0938-0581. Expira the time to review instruc- ts concerning the accuracy	evidence of accreditation for your te of application for such accreditation spond to a collection of information unleading to Date: 03/31/2024. The time required to	on within 11 mo	I OMB contr ormation co I, and comp m, please w
CAP  If you are applying for a Certificate accreditation organization as listed your Certificate of Registration.  PRA Disclosure Statement according to the Paperwork Reduction A five valid OMB control number for this in stimated to average one hour per responsive when the information collection. If you CMS, 7500 Security Boulevard, Attn. PRA end applications, claims, payments, med	of Accredita above for C act of 1995, no information col inse, including have commen Reports Clear- lical records or	ntion, you must provide LIA purposes or evidence persons are required to re- lection is 0938-0581. Expira the time to review instruc- ts concerning the accuracy ance Officer, Mail Stop C4- any documents containing	evidence of accreditation for your ce of application for such accreditation for such accreditation to a collection of information unletion Date: 03/31/2024. The time required titions, search existing data resources, gath of the time estimate(s) or suggestions for	on within 11 mo  ass it displays a valid or complete this inference that a needed in improving this for  ****CMS Disclaime is Clearance Office. I	I OMB contrormation co I, and comp m, please w r*****Pleas Please note



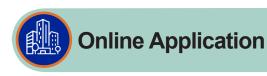
### CMS 116 form (Page 2)



- 8. "Type of Site" must match with Section III.
- 9. "Business Hours and Days" must match Section IV.



01 An	OF LA	BORATORY (C	heck the one mo	or descriptive or re				
02 An 03 An He 04 Ass 05 Bld 06 Co 07 Co	cillary Te alth Care isted Livi od Bank mmunity mp. Outp d Stage R ilysis Facil	r Surgery Center esting Site in Facility ing Facility Clinic patient Rehab Fac lenal Disease	1   1   1   1   1   1   1   1   1   1	11 Health Main. 12 Home Health 13 Hospice 14 Hospital 15 Independent 16 Industrial 17 Insurance 18 Intermediate individuals wi 19 Mobile Labora 19 Physician Offic	Agency  Care Facilities for the Intellectual story	23 24 25 26 27	Practitioner Other Prison Public Health Labc Rural Health Clinic School/Student He Skilled Nursing Fa Rursing Facility Tissue Bank/Repos Other (Specify)	oratories : alth Service cility/
IV. HOU	RS OF L	ABORATORY	TESTING (List til	mes during which la	boratory testing is ne	erformed in HH:MN	M format) If testing .	24/7 Check H
		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURE
	ROM:	SUNDAT	MONDAT	TUESDAT	WEDNESDAT	THURSDAT	FRIDAT	SATURE
	TO:						<del>-</del>	<del> </del>
(For multip		attach the addition	onal information (	using the same fo	rmat.)			
	-							
					apply for this pro		ow)	
_ *					tiple testing loca			
	_	to section VI.	-		ainder of this sec			
					to your facility's		ing site to testing	
unde Ye If yes applie	the cer s No and a m ation.	rtificate of the o	oviding the labo	oratory testing,	e base, using its a	address? e identification	n number(s) (VINs	s) and attacl
multi	rate con ple sites s \square No	?	ved tests per cer	rtificate) public	health testing an	d filing for a si	ingle certificate f	or
		the number o	f sites under the	e certificate	and list	name, address	and test perforn	ned for eacl
		ital with covera	I laboratorios lo				pus within the sa for these location	
site b 3. Is this locati	on or str	reet address an		on direction that				
site b  3. Is this locati  Ye  If yes hospi	on or str s No provide tal and s	reet address an o e the number o specialty/subspe	d under commo of sites under this ecialty areas perf	is certificate formed at each	and list		rtment, location	within
site b  3. Is this locati  Ye  If yes hospi	on or str s No provide tal and s	reet address an o e the number o specialty/subspe	d under commo of sites under this ecialty areas perf	is certificate formed at each	is filing for a sin			within
site b 3. Is this locati  Ye If yes, hospi	on or str s No provide tal and s	reet address and o e the number o specialty/subspe space is needed NAME AND	of under common of sites under this ecialty areas performed, check here ADDRESS/LOCA	is certificate formed at each and attach the	and list site below.	nation using t		
site b 3. Is this locati  Ye If yes, hospi	on or str s No provide tal and s	reet address and o e the number o specialty/subspe space is needec	of under common of sites under this ecialty areas performed, check here ADDRESS/LOCA	is certificate formed at each and attach the	and list site below.	nation using t	he same format.	
site b 3. Is this locati  Ye  If yes, hospi  If add	on or str s No provide tal and s litional s	reet address and be the number of specialty/subspecialty/	of under common of sites under this ecialty areas performed, check here ADDRESS/LOCA	is certificate formed at each and attach the	and list site below.	nation using t	he same format.	
site b 3. Is this locati  Ye  If yes, hospi  If add	on or str s No provide tal and s litional s	reet address and be the number of specialty/subspecialty/subspeciality/s	of sites under this cialty areas per it, check here ADDRESS/LOCA EPARTMENT	is certificate formed at each and attach the	and list site below.	nation using t	he same format.	
site b 3. Is this locati Ye If yes, hospi If add	on or stires No.  No. provide tal and s litional s  ABORATOR  OCATION (I	reet address and be the number of specialty/subspecialty/subspeciality/s	if sites under this cialty areas perf. d, check here  ADDRESS/LOCA EPARTMENT Cation if applicable) TELEPHONE	is certificate formed at each and attach the ATION	and list site below.	nation using t	he same format.	
site b  3. Is this locati Ye If yes hospi If add  NAME OF L  CITY, STATE  NAME OF L	on or stires No.  No.  provide tal and s ditional s  ABORATOR  ZIP CODE	reet address and be the number of specialty/subspecialty/	if sites under this cialty areas perf. d, check here  ADDRESS/LOCA EPARTMENT Cation if applicable) TELEPHONE	is certificate	and list site below.	nation using t	he same format.	
site b  3. Is this locati Ye If yes hospi If add  NAME OF L  CITY, STATE  NAME OF L	on or strict on or	reet address and on the number of specialty/subspecialty/	of under common of sites under this cialty areas per light, check here ADDRESS/LOCA EPARTMENT (action if applicable)  TELEPHONE EPARTMENT (action if applicable)	is certificate	and list site below. additional inform  T	nation using t	he same format.	

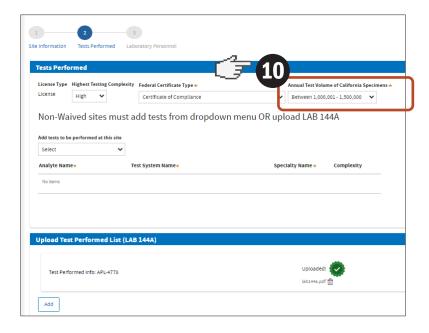


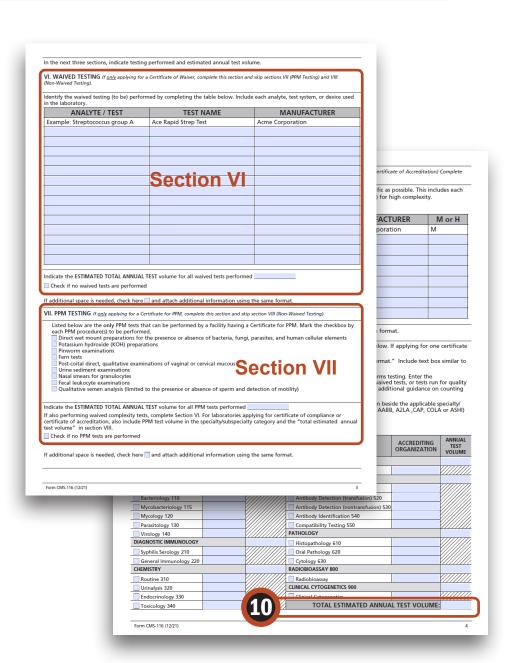
#### CMS 116 form (Pages 3 & 4)



10. "Annual Test Volume of California Specimens" and "Total Estimated Annual Test Volume" must match, if the application is for moderate/high complexity.

For Waived certificate type, complete Section VI. For PPMP, complete Section VII.

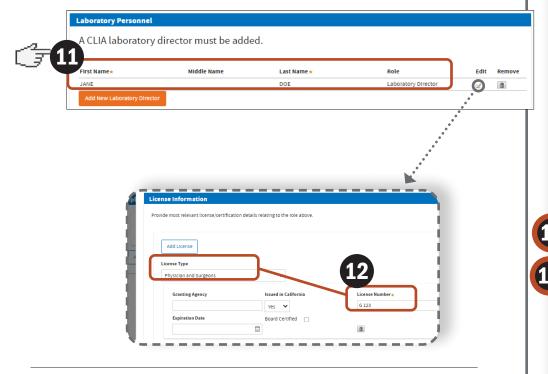






# CMS 116 form (Page 1)

The Laboratory Director (#11) and License Number (#12) must match "Name of Director" and "Credentials" on page 1 of the CMS 116 form.



Please note: All other fields on the CMS 116 form must be completed if applicable. For more details visit the CMS website.

For questions, visit our Help page: <a href="mailto:cdph.ca.gov/OnlineAppHelp">cdph.ca.gov/OnlineAppHelp</a>

CLINIC	AL LA			OVEMENT AMEN		ENTS (CLIA	1)
				THIS FORM MUST BE C		ETED.	
I. GENERAL INFORMATION				CLIA IDENTIFICATION NUM	IDED		
Initial Application	pated Sta	rt Date	CEIA IDENTIFICATION NON	IDEN			
Survey				D			
Change in Certificate T	ype			(If an initial application lea	ave blan	k. a number will b	e assigned)
Other Changes (Specify	/)			"			5
Effective Date							
FACILITY NAME				FEDERAL TAX IDENTIFICAT	ION NU	MBER	
EMAIL ADDRESS				TELEPHONE NO. (Include are	ea code)	FAX NO. (Include	area code)
RECEIVE FUTURE NOTIFICA	TIONS V	IA EMAIL					
FACILITY ADDRESS — Physical is applicable.) Fee Coupon/Certificate or corporate address is specified							
NUMBER, STREET (No P.O. Boxes)				NUMBER, STREET			
CITY	ST	ATE	ZIP CODE	CITY		STATE	ZIP CODE
SEND FEE COUPON TO THIS ADD	RESS SE	ND CERTIF	CATE TO THIS ADDRES	S CORPORATE ADDRESS (If d	ifferent	NUMBER, STREET	Г
PICK ONE:		CK ONE:		from facility) send Fee Coupor certificate	or		
Physical		Physical					
Mailing		Mailing		CITY		STATE	ZIP CODE
Corporate		Corporat	P				
NAME OF DIRECTOR (Last, First,	, Middle II	Initial)		Laboratory Director's Phon	e Numb	er	
CREDENTIALS				FOR OFFICE USE ONLY			
				Date Received			
II. TYPE OF CERTIFICATE certificate testing requiren		JESTED (	Check only one) Ple	ease refer to the accompa	nying ir	nstructions for in	spection an
Certificate of Waiver	r (Comi	nlete Sei	ctions I – VI and I	X – X)			
NOTE: Laboratory directors pe subpart M of the CLIA regulati	erforming ions. Pro	g non-wai oof of thes	ved testing (including e qualifications for th	PPM) must meet specific ed	e submit	tted with this appl	lication.
Certificate of Compl	iance (	Complet	te Sections I – X)				
				and indicate which of the			
The Joint Com	nmissio	n [	ACHC	AABB	2LA		
CAP			COLA	ASHI			
If you are applying for a Certii accreditation organization as I your Certificate of Registration	listed abo						
PRA Disclosure Statement							
According to the Paperwork Reduc The valid OMB control number for estimated to average one hour per review the information collection. CMS, 7500 Security Boulevard, Attr	this information the transfer of the transfer	mation colle , including ve comment	ection is 0938-0581. Expi the time to review instru s concerning the accurac	ration Date: 03/31/2024. The time r ctions, search existing data resou y of the time estimate(s) or sugge	equired t rces, gath estions fo	o complete this infor ner the data needed, r improving this form	rmation collection and complete a n, please write t