



Contra Costa County Health Services Department

Public Health Division

**NONDIAGNOSTIC GENERAL HEALTH ASSESSMENT  
RENEWAL FORM**

**This registration form must be completed annually and received by the Contra Costa County Public Health Department at least 30 days prior to operating a program of nondiagnostic general health assessment.**

**PART 1: ADMINISTRATAION**

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

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

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Bus. Ph: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ CLIA #: \_\_\_\_\_ Exp: \_\_\_\_\_

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

Address (if Different Than Above): \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

C. **Supervisory Committee Members:**

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

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

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

City State Zip Code

California Medical License #: \_\_\_\_\_ Expiration: \_\_\_\_\_

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

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

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

City State Zip Code

California Clinical Laboratory Scientist License #: \_\_\_\_\_ Expiration: \_\_\_\_\_

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 Contra Costa County Health Officer must be notified in writing within 30 days of any change in record storage location.**

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

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

City State Zip Code

**PART 2: ASSESSMENT PROGRAM**

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

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

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

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

B. **Dates and Hours Program will be Operating at this Location** (attach additional sheets if necessary):

Date	Hours	Date	Hours

**NOTE: ANY CHANGES IN TIMES, DATES OR LOCATION MUST BE REPORTED IN WRITING TO THE HEALTH DEPARTMENT AT LEAST 24 HOURS PRIOR TO THE OPERATION OF THE PROGRAM.**

C. **Nondiagnostic Test Conducted at this location.**

(✓)	Test	Equipment Name	Manufacturer
	TOTAL CHOLESTEROL		
	HIGH DENSITY LIPOPROTEIN (HDL)		
	LOW DENSITY LIPOPROTEIN (LDL)		
	TRIGLYCERIDES		
	BLOOD GLUCOSE		
	HEMOGLOBIN		
	DIPSTICK URINALYSIS		
	FECAL OCCULT BLOOD		
	URINE PREGNANCY		

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

<u>Name</u>	<u>Title</u>	(✓) Authorized to perform skin puncture	
		Yes	No

**NOTE: Include documentation of authorization to perform skin puncture for each individual checked "Yes" above.**

**PART 3: COMPLIANCE**

**All assessment programs must be operated per § 1244 of the California Business and Professions Code. Please answer each of the questions listed below.**

- Yes No  
[ ] [ ] The organization/operator listed on this application has and will continue to operate in accordance with all applicable Federal, State and County regulations in its provision of Non-diagnostic General Health Assessment Programs.
- [ ] [ ] An annual review by the supervisory committee of all written protocols has been performed and documented with a signed and dated statement made by both supervisory committee members. A copy of this document is included with this application.
- [ ] [ ] All protocols and procedures followed in this program have been submitted to the Contra Costa County Non-diagnostic General Health Assessment Office for review or all new procedures are enclosed with this application.

**PART 4: FEES (LICENCE VALID ONE YEAR)**

- Annual fee: \$200

Make Checks Payable to: **Contra Costa County**

**Return Application to: Contra Costa Public Health Lab  
NGHA Program  
2500 Alhambra Avenue, Room 209  
Martinez, CA 94553**

**PART 5: LICENSE**

Name of Person Requesting License: \_\_\_\_\_ Phone no. \_\_\_\_\_

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

\_\_\_\_\_  
City State Zip code email address

*I certify that the above information is accurate and complete and that I am aware of the laws and regulations that apply to non-diagnostic testing in the State of California and in the County of Contra Costa in which testing is to be performed.*

\_\_\_\_\_  
Applicant's signature

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

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**FOR OFFICIAL USE ONLY**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Date Received: \_\_\_\_\_

License #: \_\_\_\_\_ Date: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**PART 2A: ADDITIONAL ASSESSMENT PROGRAM LOCATION**

Complete a separate PART 2A for each location where assessments are to be performed.

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

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

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code  
 Business Phone: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_ CLIA #: \_\_\_\_\_

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

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

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

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

C. **Dates and Hours Program will operate at this location (attach additional sheets if necessary):**

Date	Hours	Date	Hours

**Note: Any changes in dates, times, or locations must be reported in writing to the Health Department at least 24 hours prior to the operation of the program.**

D. **Nondiagnostic Tests Conducted at this location:**

(✓)	Test	Equipment Name	Manufacturer
	TOTAL CHOLESTEROL		
	HIGH DENSITY LIPOPROTEIN (HDL)		
	LOW DENSITY LIPOPROTEIN (LDL)		
	TRIGLYCERIDES		
	BLOOD GLUCOSE		
	HEMOGLOBIN		
	DIPSTICK URINALYSIS		
	FECAL OCCULT BLOOD		
	URINE PREGNANCY		

**E. List of Employees for this location (attach additional sheets if necessary).**

<u>Name</u>	<u>Title</u>	<b>(✓) Authorized to perform skin puncture</b>	
		<b>Yes</b>	<b>No</b>

**NOTE: Include documentation of authorization to perform skin puncture for each individual checked “Yes” above.**

**F. LICENSE**

Name of Person Requesting License: \_\_\_\_\_ Phone no. \_\_\_\_\_

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

\_\_\_\_\_  
 City State Zip code email address

I certify that the above information is accurate and complete and that I am aware of the laws and regulations that apply to non-diagnostic testing in the State of California and in the County of Contra Costa in which testing is to be performed.

\_\_\_\_\_  
 Applicant’s signature

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

**FOR OFFICIAL USE ONLY**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Received Date: \_\_\_\_\_

License #: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_