



# RI Department of Health

## Application and instructions for

# Blood Testing Screening Permit

[RI General Law Chapter 23-16.2](#)

Name: \_\_\_\_\_

Permit Number: \_\_\_\_\_

*Note: This is a nonrenewable permit which must be reapplied for annually*



## INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your permit will not be issued. Please use a ballpoint pen.
- The fee for this application is \$70.00
- Payment must be made in the form of a check or money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application, return it with the required fee and mail to:  
 Rhode Island Department of Health  
 3 Capitol Hill, Room 306  
 Providence, RI 02908-5097.
- If you have any questions concerning this application, call the office of Facilities Regulations at (401) 222-2566.
- Licensure/permit application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

**Attachments:** Please label and staple each separate attachment and securely affix all attachments to this application.

1. The procedure(s) for monitoring, obtaining informed consents, interpretation and reporting of test results, and follow-up on positive findings, participant education, and referral of identified cases, including an explanation of results, and recommendations for appropriate treatment, prevention and control;
2. Analytical method(s) to be used, type of equipment and/or instrument(s) to be used, and documented evidence to determine accuracy and precision of the instrument(s);
3. A description of the supervisory methods and quality controls, in accordance with [§ 1.5.3 of this Part](#);
4. Staff training program and qualifications of staff; Copies of educational materials pertaining to specific test(s) and condition(s) to be distributed to the general public at the screening site;
5. Quality control and instrument maintenance records;
6. Provisions to handle emergencies; and
7. Procedures for the disposal of medical waste

**All persons conducting screening programs shall be required to submit a schedule of each screening site, clearly identifying the specific screening tests to be conducted, and the dates, times and locations of the screening program.**

**Please complete the following:**

<b>License/permit Sub-Type:</b> Please select one	<input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit
<b>Medical Director Information:</b> Please provide the name of the Medical Director for this site.  <b>Note: This section must be completed as a requirement for your permit.</b>	Name: _____  RI License Number: _____
<b>Federal CLIA Provider Number</b>	Federal CLIA Provider Number: _____



<p><b>Facility Name:</b></p> <p>Please provide the name of the facility (as known to the public).</p>	<p>Name: _____</p>
<p><b>Facility Contact Person:</b></p> <p>Please provide the name and telephone number of a person we can contact concerning this facility.</p>	<p>Name: _____</p> <p>Phone Number: (     ) _____</p>
<p><b>Facility Mailing Information:</b></p> <p>Please provide the mailing information for all communication regarding this license/permit.</p> <p><b>(Not published on HEALTH website).</b></p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, Zip Code _____</p> <p>Address Country _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p><b>Facility Location Information:</b></p> <p>Please provide the location information for this facility.</p> <p><b>(Published on HEALTH website).</b></p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, Zip Code _____</p> <p>Address Country _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p><b>Ownership Type:</b></p> <p>Please check ONE</p>	<p><input type="checkbox"/> Corporation                      <input type="checkbox"/> Limited Liability Company</p> <p><input type="checkbox"/> Governmental Entity              <input type="checkbox"/> Sole Proprietorship</p> <p><input type="checkbox"/> Partnership                          <input type="checkbox"/> Limited Partnership</p> <p><input type="checkbox"/> Partner</p>
<p><b>Ownership Information:</b></p> <p>Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity per page 2 instructions.</p>	<p>Name: _____</p> <p>DBA: _____</p>



<p><b>Ownership Address Information:</b></p> <p>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, Zip Code _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p><b>Parent Organization, Group Affiliation:</b></p> <p>Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control</p>	<p>Corporation Type _____</p> <p>Name of Organization _____</p> <p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, Zip Code _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p><b>Land/Building Info:</b></p> <p>If the owner of the land and building is other than the operator of this agency/facility, please complete the following:</p>	<p>Name: _____</p> <p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, Zip Code _____</p> <p>Phone _____</p>
<p><b>On-site supervisor (s)</b></p> <p>Please list the name(s) and qualifications of the on-site supervisor(s).</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Screening Tests:</b></p> <p>Please select the specific screening tests to be offered</p>	<p><input type="checkbox"/> Glucose                      <input type="checkbox"/> Hematocrit                      <input type="checkbox"/> Hemoglobin</p> <p><input type="checkbox"/> Cholesterol                      <input type="checkbox"/> HDL                                      <input type="checkbox"/> Triglyceride</p> <p><input type="checkbox"/> Other (Please list tests) - _____</p>



### Acknowledgements

I am aware of Chapter 23-16.2 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-16.2 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

**FEIN Number:**  
(Federal Employer Identification Number)

**Note:** If you are a sole proprietor this number may be your Social Security Number.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

SSN/F.E.I.N. Number: \_\_\_\_\_

#### Affidavit of Applicant

Read, sign, and date this affidavit.

#### AFFIDAVIT AND SIGNATURE

#### This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

\_\_\_\_\_  
Printed Name of Authorized Person

\_\_\_\_\_  
Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.