RI Department of Health

Application
and instructions for

Blood Testing Screening Permit
RI General Law Chapter 23-16.2

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

1. ☐ Initial Licensure
2. ☐ Change of ownership
3. ☐ Change of address
4. ☐ Licensee/Facility Name Change

(Complete the following for either 1, 2, or 3)

Current facility name:_____ License #:_____

Current address:_____

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- The fee for this application is $70.00
- Make your check/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.
- **You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.**
- **Also, you must attach a written description of the program as described in Sections 3.1, c, l thru ix, as specified in the latest Rules and Regulations Pertaining to permits for Screening Programs (R23-16.2-SCRE).**

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

Please complete the following:

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

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

Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone: _____ Fax: _____ Email Address: _____
Parent Organization, Group Affiliation: 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	Corporation Type _____ Name of Organization _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone: _____ Fax: _____ Email Address: _____
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Phone
On-site supervisor (s) Please list the name(s) and qualifications of the on-site supervisor(s).	_____ _____ _____ _____ _____ _____
Screening Tests: Please select the specific screening tests to be offered	☐ Glucose ☐ Hematocrit ☐ Hemoglobin ☐ Cholesterol ☐ HDL ☐ Triglyceride ☐ Other (Please list tests) _____

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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.