**REQUEST FOR CLIA CERTIFICATION COVERAGE OF PUBLIC HEALTH EDUCATION EVENT LABORATORY TESTING**

**SCHOOL/DEPARTMENT: SSPPS\_\_\_\_\_\_\_\_; SOM/Unit\_\_\_\_\_\_\_\_\_\_\_**

**(Please complete and submit this form at least ten days prior to the event.**

**E-mail to David N. Bailey, M.D., Deputy Dean, SSPPS at** [**dnbailey@ucsd.edu**](mailto:dnbailey@ucsd.edu)**. If there are questions, please call David Bailey at 858: 822-5551).**

**PLEASE NOTE: ALL EVENTS MUST BE PUBLIC HEALTH EDUCATION EVENTS WHOSE PURPOSE IS TO EDUCATE THE PUBLIC; THESE ARE NOT TO BE HEALTH ASSESSMENT EVENTS; PROMINENT SIGNAGE MUST INDICATE THAT THIS IS A PUBLIC HEALTH EDUCATION EVENT; WHILE RESULTS CAN BE GIVEN TO THE PARTICIPANT, WE ARE NOT LICENSED TO REFER THEM TO A SPECIFIC PROVIDER FOR FOLLOWUP**

**NAME OF EVENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF EVENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FACULTY PRECEPTOR OF EVENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STUDENT ORGANIZER OF EVENT/YEAR OF TRAINING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YEAR(S) OF TRAINING OF STUDENTS PERFORMING THE LABORATORY TESTING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LABORATORY TEST(S) TO BE PERFORMED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DEVICE(S) TO BE USED FOR THE LABORATORY TESTING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTESTATIONS (PLEASE READ AND INITIAL):**

1. **I attest that the performers of the laboratory test(s) have been/will be trained in proper operation of the device according to the device manufacturer’s specifications.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **I attest that the laboratory test(s) will be performed according to all recommendations of the device manufacturer, including reagent handling and storage, quality control, and device handling.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **I attest that there will be proper biohazardous waste disposal, blood-handling precautions, observation of hygiene, and clean areas to perform the laboratory test(s).**

**PRINTED NAMES AND SIGNATURES:**

**Student/Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Faculty Preceptor/Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPROVAL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; CLIA License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**