

### LABORATORY PERSONNEL REPORT (CLIA) (For moderate and high complexity testing)

|   |                               |
|---|-------------------------------|
| 1. LABORATORY NAME                        | 2. CLIA IDENTIFICATION NUMBER |
| 3. LABORATORY ADDRESS (NUMBER AND STREET) | CITY                          |
|   | STATE                         |
|   | ZIP CODE                      |

|  |   |  |
|--|---|--|
| <p><b>4. Instructions:</b></p> <p>a. List below all technical personnel, by name, who are employed by the laboratory. Check (✓) the appropriate column for each position held. For TC and TS follow instructions on reverse.</p> <p>b. Indicate whether shift worked is (1) day, (2) evening or (3) night.</p> <p>c. Indicate highest level of testing for which personnel are qualified: Use (M) for moderate and (H) for high complexity.</p> <p>d. Indicate whether position held is full (F) or part-time (P).</p> | <p><b>Positions:</b></p> <p>D-Director<br/>CC - Clinical Consultant<br/>TC - Technical Consultant<br/>TS - Technical Supervisor<br/>GS - General Supervisor<br/>TP- Testing Personnel<br/>CT/GS - Cytology General Supervisor<br/>CT - Cytotechnologist</p> | <p>5. TELEPHONE (INCLUDE AREA CODE)</p> <hr/> <p style="text-align: center;"><b>FOR OFFICIAL USE ONLY</b><br/>(NOT TO BE COMPLETED BY LABORATORY)<br/>QUALIFIES ACCORDING TO SUBPART M</p> |
|--|---|--|

| EMPLOYEE NAMES |            |    | a. POSITION HELD |    |    |    |    |    |       |    |                       |   |   | b. | c.                              | d.   | DATE OF SURVEY _____                      |  |  |  |
|----------------|------------|----|------------------|----|----|----|----|----|-------|----|-----------------------|---|---|----|---------------------------------|--|---|--|--|--|
| LAST NAME      | FIRST NAME | MI | D                | CC | TC | TS | GS | TP | CT/GS | CT | S<br>H<br>I<br>F<br>T | 1 | 2 | 3  | M<br>O<br>R<br>N<br>I<br>N<br>G | F<br>O<br>R<br>E<br>V<br>E<br>N<br>I<br>N<br>G | P<br>A<br>R<br>T<br>-<br>T<br>I<br>M<br>E |  |  |  |
|                |            |    |                  |    |    |    |    |    |       |    |                       |   |   |    |                                 |  |   |  |  |  |
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|                |            |    |                  |    |    |    |    |    |       |    |                       |   |   |    |                                 |  |   |  |  |  |

Check (✓) here if additional space is needed to list all technical personnel. Copy this page and attach continuation sheet(s) to the original form.

**READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

Statement or Entities Generally: Whoever, in any manner within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statements or entry, shall be fined not more than \$10,000 or imprisoned not more than five years, or both. (U.S. Code, Title 18, Sec. 1001)

**CERTIFICATION:** I CERTIFY THAT ALL OF THE INDIVIDUALS LISTED ABOVE QUALIFY, TO FUNCTION IN THE POSITION INDICATED, ACCORDING TO THE PERSONNEL REGULATIONS OF 42 CFR PART 493 SUBPART M.

|                                     |         |
|-------------------------------------|---------|
| 6. SIGNATURE OF LABORATORY DIRECTOR | 7. DATE |
|-------------------------------------|---------|

## INSTRUCTIONS FORM CMS-209

This form will be completed by the laboratory. It will be used by the surveyor to review the qualifications of technical personnel in the laboratory.

### Instructions for 4(a) TC/TS:

When listing those individuals holding technical consultant/technical supervisor (TC/TS) positions, use the following grid to indicate the specialty(ies)/subspecialty(ies) in which they presently function. Record the number corresponding to the specialty/subspecialty in the appropriate column (TC/TS). When an individual functions as a TC/TS in more than one specialty/subspecialty, use a line for each specialty/subspecialty.

**GRID:**

- |                          |                           |
|--------------------------|---------------------------|
| 1. Bacteriology          | 10. Clinical Cytogenetics |
| 2. Mycobacteriology      | 11. Histocompatibility    |
| 3. Mycology              | 12. Radiobioassay         |
| 4. Parasitology          | 13. Histopathology        |
| 5. Virology              | 14. Oral Pathology        |
| 6. Diagnostic Immunology | 15. Cytology              |
| 7. Chemistry             | 16. Dermatopathology      |
| 8. Hematology            | 17. Ophthalmic Pathology  |
| 9. Immunohematology      |                           |

### EXAMPLE

| EMPLOYEE NAMES |            |    | a.            |    |    |    |    |    |       |    |                       | b.          | c.           | d.           |
|----------------|------------|----|---------------|----|----|----|----|----|-------|----|-----------------------|-------------|--------------|--------------|
|                |            |    | POSITION HELD |    |    |    |    |    |       |    |                       |             |              |              |
| LAST NAME      | FIRST NAME | MI | D             | CC | TC | TS | GS | TP | CT/GS | CT | S<br>H<br>I<br>F<br>T | 1<br>2<br>3 | M<br>OR<br>H | F<br>OR<br>P |
| Smith          | John       |    |               |    | 1  |    |    |    |       |    |                       | 1           | M            | F            |
|                |            |    |               |    |    | 4  |    |    |       |    |                       |             | H            |              |
|                |            |    |               |    |    | 6  |    |    |       |    |                       |             | H            |              |

### FOR OFFICIAL USE ONLY

Indicate the applicable regulatory citation under which the following individuals are qualified: Each laboratory director, technical consultant, technical supervisor, clinical consultant, general supervisor, cytology supervisor, and those testing personnel and cytotechnologist sampled during the survey process.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0151. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.