SURVEY REPORT FORM (CLIA)

SURVEYOR INSTRUCTIONS FOR CMS 1557

- For **specialty(ies)/subspecialty(ies) added or deleted:** Use the space provided to list corresponding information and effective dates.
- For **proficiency testing**: Any comments pertinent to the survey or determination of compliance can be listed here.
- Each surveyor must **sign the certifying statement** on page 2 for each type of survey conducted *(see "survey status;" "other" may include follow-up visit to verify a POC).*

GENERAL INFORMATION

CLIA IDENTIFICATION NUMBER	DATE OF SURVEY		
LABORATORY NAME	TELEPHONE NUMBER *(include area code)*		
LABORATORY ADDRESS *(number, street)*	CITY	STATE	ZIP
MAILING ADDRESS (if different from above)	CITY	STATE	ZIP

NAME OF DIRECTOR
last *first* *MI*

SURVEY STATUS: *(Check all that apply)*

- ☐ Initial Certification
- ☐ Recertification
- ☐ Validation
- ☐ Complaint
- ☐ State Exemption *(State)* _____
- ☐ Accreditation *(Organization)* _____
- ☐ Addition of (Sub)Specialty(ies)
- ☐ Other *(Specify)* _____

STATE/COUNTY CODE | STATE REGION CODE

STATE LICENSE NUMBER *(if applicable)*

MEDICARE PROVIDER NUMBER(S)

PERSONNEL: SHOW NUMBER OF PEOPLE QUALIFIED UNDER EACH APPLICABLE REGULATORY SECTION

DIRECTOR
MODERATE COMPLEXITY
493.1405(a) and

(b)(1) _____ (6) _____
(2) _____ (7) _____
(3) _____ ( ) _____
(4) _____ ( ) _____
(5) _____ ( ) _____

CLINICAL CONSULTANT
MODERATE COMPLEXITY
493.1417

(a) _____
(b) _____
( ) _____
( ) _____

TECHNICAL CONSULTANT
MODERATE COMPLEXITY
493.1411(a) and

b) (1) _____ ( ) _____
(2) _____ ( ) _____
(3) _____
(4) _____

DIRECTOR
HIGH COMPLEXITY
493.1443(a) and

(b)(1) _____ ( ) _____
(2) _____ ( ) _____
(3) _____
(4) _____
(5) _____

CLINICAL CONSULTANT
HIGH COMPLEXITY
493.1455

(a) _____
(b) _____
( ) _____
( ) _____

TECHNICAL SUPERVISOR
HIGH COMPLEXITY
493.1449(a) and

(b) _____ (h) _____ (n) _____
(c) _____ (i) _____ (o) _____
(d) _____ (j) _____ (p) _____
(e) _____ (*) _____ (q) _____
(f) _____ (l) _____ ( ) _____
(g) _____ (m) _____ ( ) _____

GENERAL SUPERVISOR
HIGH COMPLEXITY
493.1461(a) and

(b)(1) _____ (d)(1) _____
(b)(2) _____ (d)(2) _____
(c)(1) _____ (d)(3) _____
(c)(2) _____ (e) _____
(c)(3) _____ ( ) _____

CYTOTECHNOLOGIST
493.1483(a) and

(b)(1) _____ (4) _____
(2) _____ (5) _____
(3) _____ ( ) _____

TECHNICAL SUPERVISOR
CYTOLOGY
***493.1449(a) and**

(k)(1) _____ ( ) _____
(2) _____ ( ) _____

GENERAL SUPERVISOR
CYTOLOGY
493.1469

(a) _____ ( ) _____
(b) _____ ( ) _____

SPECIALTIES/SUBSPECIALTIES	ACCREDITED PROGRAM	ANNUAL TEST VOLUMES	(SUB)SPECIALTY(IES) ADDED EFFECTIVE DATE	(SUB)SPECIALTY(IES) DELETED EFFECTIVE DATE	PROFICIENCY TESTING
010 ☐ Histocompatibility	_____	_____	_____	_____	NA
A ☐ Transplant					
B ☐ Nontransplant					
100 ☐ Microbiology	_____	_____	_____	_____	_____
110 ☐ Bacteriology	_____		_____	_____	_____
115 ☐ Mycobacteriology	_____		_____	_____	_____
120 ☐ Mycology	_____		_____	_____	_____
130 ☐ Parasitology	_____		_____	_____	_____
140 ☐ Virology	_____		_____	_____	_____
150 ☐ Other	_____		_____	_____	_____
200 ☐ Diagnostic Immunology	_____	_____	_____	_____	_____
210 ☐ Syphilis Serology	_____		_____	_____	_____
220 ☐ General Immunology	_____		_____	_____	_____
300 ☐ Chemistry	_____	_____	_____	_____	_____
310 ☐ Routine	_____		_____	_____	_____
320 ☐ Urinalysis	_____		_____	_____	_____
330 ☐ Endocrinology	_____		_____	_____	_____
340 ☐ Toxicology	_____		_____	_____	_____
350 ☐ Other	_____		_____	_____	_____
400 ☐ Hemotology	_____	_____	_____	_____	_____
500 ☐ Immunohematology	_____	_____	_____	_____	_____
510 ☐ ABO Group & Rh Type	_____		_____	_____	_____
520 ☐ Antibody Detection (transfusion)	_____		_____	_____	_____
530 ☐ Antibody Detection (nontransfusion)	_____		_____	_____	_____
540 ☐ Antibody Identification	_____		_____	_____	_____
550 ☐ Compatibility Testing	_____		_____	_____	_____
560 ☐ Other	_____		_____	_____	_____
600 ☐ Pathology	_____	_____	_____	_____	_____
610 ☐ Histopathology	_____		_____	_____	NA
620 ☐ Oral pathology	_____		_____	_____	NA
630 ☐ Cytology	_____		_____	_____	_____
800 ☐ Radiobioassay	_____	_____	_____	_____	NA
900 ☐ Clinical Cytogenetics	_____	_____	_____	_____	NA

Are immunohematology tests performed for transfusion purposes? ..... ☐ Yes ☐ No

Are blood and/or blood products (including autologous) collected? ..... ☐ Yes ☐ No

For a partial survey (validation, addition of (sub)specialty, complaint, or follow-up) list the laboratory condition(s) regulation number(s) reviewed:

_____ _____ _____

_____ _____ _____

_____ _____ _____

In accordance with current survey procedures, this laboratory was found to be in compliance with program requirements.

SIGNATURE	DATE
SIGNATURE	DATE
SIGNATURE	DATE

SURVEY WORKSHEET (CLIA)

NAME OF SURVEYOR	DATE OF SURVEY (MMDDYY)
NAME OF FACILITY	CLIA IDENTIFICATION NUMBER

SURVEY WORKSHEET (CLIA) *(CONTINUED)*