Provider Performed Microscopic Procedures (PPMP) Application Packet

Contents:

1. 505-041 ....Provider Performed Microscopic Procedures (PPMP) Application Index Page .... 1 Page
2. 505-042 ....Provider Performed Microscopic Procedures (PPMP) Application Instructions Checklist... 2 Pages
3. 505-031 ....Provider Performed Microscopic Procedures (PPMP) Application.. 7 Pages

Important Information:

Laboratories licensed by the Washington Medical Test Site (MTS) licensure program are exempt from the Clinical Laboratory Improvement Amendments of 1988 (CLIA). You do not need to apply to the Centers for Medicare and Medicaid Services (CMS) for a CLIA number. Your MTS license will contain both your MTS license number and your CLIA number.

If the application you are submitting is handwritten, please ensure the information is written clearly, accurately, and legibly in order to ensure there is no delay in processing.

In order to process your request:

Return Completed Application (original copy) and your fee in the form of check or money order (made out to the Department of Health) to:

Department of Health
Revenue Section
P.O. Box 1099
Olympia, WA 98507-1099

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Provider Performed Microscopic Procedures (PPMP) Application Instructions Checklist

When your application for a Medical Test Site is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Indicate type of application:**

- New
- Change of ownership
- Change of license type

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **Section 1. Demographic Information:**
Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one. If the facility FEIN # is different than the Legal Owner FEIN, enter this number on page two of the application under Facility Specific Federal Tax ID (FEIN) #.

Legal Owner/Operator Entity Name: Enter the owner's name as it appears on the UBI/Master Business License.

Legal Owner Mailing Address: Enter the owner's complete mailing address.

Phone and Fax: Enter the owner's phone and fax numbers.

Email and Web Address: Enter the owner's email and facility web addresses, if applicable.

Facility Name: Enter the lab's name as advertised on signs and web site.

Facility Specific Federal Tax ID (FEIN) #. Enter if different from the Owner FEIN listed on page one of the application.

Physical Address: Enter the lab's physical street location including city, state, zip code, and county.

Phone and Fax Numbers: Enter the lab's phone and fax number.

Mailing Address: Enter the lab's mailing address, if different than physical address.

☐ **Section 2. Facility Specific Information:**
Site Type: Please check one applicable site type.

Hours of Laboratory Testing: List the days and hours of testing for this site.

Additional locations under this license: Attach a list of names, addresses and phone numbers for additional locations, if applicable, and test(s) performed at each site.

☐ **Section 3. Key Individuals:**
Lab Director: Enter the lab director's:

1. Name of MD, DO, DPM, ARNP, midwife, PA, naturopath, or dentist
2. Washington State professional license number, if applicable
3. Email address

Lab Contact: Enter the lab contact's:

1. Name
2. Washington State professional license number, if applicable
3. Email address

The lab contact will receive all information that we mail to your medical test site.

☐ **Section 4. Additional Information—Waived Tests:**
Waived Tests:

Indicate the test manufacturer(s) and test system(s) on the lines provided. Be as specific as possible. Please verify the waived status of your test system at https://www.accessdata.fda.gov.

PPMP Tests: Place a checkmark by all PPMP tests performed at your facility by one of the providers listed. The PPMP tests can only be performed in your facility by an MD, DO, DPM, ARNP, midwife, PA, naturopath, or dentist.

If you perform any tests other than the waived or PPMP tests listed, do not complete this application. See the LQA website: **http://www.doh.wa.gov/lqa.htm** to help you determine your correct license category or call Customer Service at 360-236-4700.

☐ **Section 5. Other Licensure, Certification, or Registration Information:**
Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, LLC members or manager, partners, etc. Attach additional pages, if necessary.

☐ **Section 6. Foreign Ownership:** Complete if facility is owned fully or partially by foreign entity.

Change of Ownership Information: If applicable, list the previous legal owner name, previous name of facility, previous MTS license number, effective date of ownership change and physical address.

☐ **Signature:**
Signature of legal owner or authorized representative

Date signed

Print name of legal owner or authorized representative

Print title of legal owner or authorized representative

Your new MTS license will expire on June 30, 2023. You will receive a renewal notice for this license approximately 60 days before the expiration date.

Please contact Customer Service at 360-236-4700 if you have any questions or need assistance in completing the application form. Additional information is available on our website at: **http://www.doh.wa.gov/lqa.htm**.

Revenue Section
P.O. Box 1099
Olympia, WA 98507-1099
360-236-4700
http://www.doh.wa.gov/LQA.htm

Revenue: 0420030000

Fee
☐ July 1, 2022 – June 30, 2023.......$125.00

Date Stamp Here

Provider Performed Microscopic Procedures (PPMP) Medical Test Site License Application

This is for: ☐ New ☐ Change of Ownership ☐ Change of License Type

Check One

☐ Association	☐ Limited Partnership	☐ Partnership
☐ Corporation	☐ Municipality (City)	☐ Sole Proprietor
☐ Limited Liability Company	☐ Municipality (County)	☐ State Government Agency
☐ Limited Liability Partnership	☐ Non-Profit Corporation	☐ Trust

Section 1. Demographic Information

UBI #	Federal Tax ID (FEIN) #

Legal Owner/Operator Entity Name

Mailing Address

City	State	Zip Code	County

Phone (enter 10 digit #)	Fax (enter 10 digit #)
Email Address	Web Address

Facility/Agency Name (Business name as advertised on signs or website)

Facility Specific Federal Tax ID (if different than one entered above.)

Physical Address

City	State	Zip Code	County

Facility Phone (enter 10 digit #)	Facility Fax (enter 10 digit #)

Mailing Address (If different than physical address)

City	State	Zip Code	County

For Office Use Only

Medical Test Site # ________________________________ CLIA # ________________________________

Section 2. Facility Specific Information

Site Type (check one only)

___ 1 Ambulance
___ 2 Ambulatory Surgery Center
___ 3 Ancillary Test Site
___ 4 Assisted Living Facility
___ 5 Blood Banks
___ 6 Community Clinic
___ 7 Comprehensive Outpatient Rehab
___ 8 End Stage Renal Disease Dialysis
___ 9 Federally Qualified Health Center
___ 10 Health Fair
___ 11 Health Main. Organization
___ 12 Home Health Agency
___ 13 Hospice
___ 14 Hospital
___ 15 Independent Laboratory
___ 16 Industrial
___ 17 Insurance
___ 18 ICFMR
___ 19 Mobile Lab
___ 20 Pharmacy
___ 21 Physician Office
___ 22 Other Practitioner ___________
___ 23 Prison
___ 24 Public Health Lab
___ 25 Rural Health Clinic
___ 26 Student Health Service
___ 27 Skilled Nursing Facility
___ 28 Tissue Bank/Repository
___ 29 Drug Treatment
___ 30 Clinic
___ 31 Adult Family Home

Hours of Laboratory Testing

List days and times during which **laboratory testing** is performed. **If testing 24/7 check here** ☐

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From:							
To:							

Additional locations under this license

If you qualify as a not-for-profit laboratory or state or local government laboratory that performs limited public health testing (total of 15 or less waived or moderate complexity tests) at different locations, you may apply for one license.

This license will have additional locations under one license and the paragraph above applies: ☐ Yes ☐ No

If yes: Attach a list of names, addresses and phone numbers for each site that will be included under one license, and a list of tests performed at each site. If any of the sites already have a MTS license, include the MTS and CLIA numbers of the sites that will be consolidated under this license. If you are not a state or local government laboratory, you **must** include a copy of your federal 501(c)(3) determination letter to be licensed in this manner.

Section 3. Key Individuals

Lab Director (include MD, DO, DMP, ARNP, Midwife, PA, Naturopath, or Dentist)

Name

Washington State Professional License

Email Address

Lab Contact Person

Name

Washington State Professional License (if applicable)

Email Address

Note: **If your test kit doesn't appear on the FDA-approved waived test list, do not complete this application.** See the FDA website to check that your test kits are for waived use and to determine the correct license category for your site based on the test kit you intend to use.

Section 4. Additional Information—Waived Tests

Waived Tests: Please indicate the test system(s) on the lines below and verify the waived status of your test system on the FDA/CLIA Test Complexity Database. e.g. (Rapid Strep, Acme Home Glucose Meter)

Adenovirus ______________________________

Aerobic/Anaerobic Organisms - Vaginal ______________________________

Aerobic/Anaerobic/Viral Panel - Respiratory ______________________________

Alanine Aminotransferase (ALT) ______________________________

Albumin ______________________________

Alkaline Phosphatase (ALP) ______________________________

Amylase ______________________________

Aspartate Aminotransferase (AST) ______________________________

B-Type Natriuretic Peptide (BNP) ______________________________

Bilirubin, Total ______________________________

Bladder Tumor Associated Antigen ______________________________

BUN (Blood Urea Nitrogen) ______________________________

Calcium ______________________________

Calcium - Ionized ______________________________

Carbon Dioxide (CO_2) ______________________________

Catalase, urine ______________________________

Chloride ______________________________

Cholesterol ______________________________

Complete Blood Count (CBC) ______________________________

Creatine Kinase (CK) ______________________________

Creatinine ______________________________

Waived Tests (continued)

Drugs of Abuse ____________________

Electrolyte Panel ____________________

Erythrocyte sedimentation rate (ESR) ____________________

Esterone-3-Glucuronide ____________________

Ethanol ____________________

Follicle Stimulating Hormone (FSH) ____________________

Fructosamine ____________________

Gamma Glutamyl Transferase (GGT) ____________________

Glucose ____________________

Glycosylated HGB (Hemoglobin A1C) ____________________

HDL Cholesterol ____________________

Helicobacter pylori ____________________

Hematocrit ____________________

Hemoglobin ____________________

Hepatitis C Virus Antibody ____________________

HIV-1 ____________________

Influenza ____________________

Ketones (Blood) ____________________

Lactic Acid ____________________

LDL Cholesterol ____________________

Lead ____________________

Lithium ____________________

Waived Tests (continued)

Lyme Disease ____________________

Lutenizing Hormone (also see ovulation tests) ____________________

Matrix metalloproteinases-9 (MMP-9) ____________________

Microalbumin ____________________

Mononucleosis ____________________

Nicotine (or its metabolites) ____________________

Occult Blood ____________________

Osmolarity ____________________

Osteoporosis ____________________

Ovulation Tests ____________________

PH ____________________

Phosphorus ____________________

Platelet Aggregation ____________________

Potassium ____________________

Pregnancy Test (Urine) ____________________

Protime ____________________

Protein, Total ____________________

RSV (Respiratory Syncytial Virus Direct Antigen) ____________________

SARS-CoV-2 (COVID-19) ____________________

Semen ____________________

Sodium ____________________

Strep Antigen Test ____________________

Waived Tests (continued)

Syphilis ____________________

Trichomonas ____________________

Triglycerides ____________________

TSH ____________________

Uric Acid ____________________

Urinalysis ____________________

Other Tests Not Listed Above ____________________

____

____

Provider-Performed Microscopic Procedures (PPMP)

These tests can **only** be performed in your office by an MD, DO, DPM, ARNP, midwife, PA, naturopath, or dentist. You do **not** qualify for this license type if these tests are performed by any other personnel in your office.

See the LQA Web site: **http://www.doh.wa.gov/lqa.htm** to help you determine your correct license category or call Customer Service at 360-236-4700.

Check all that apply

__ Direct wet mount preparations for the presence or absence of bacteria, fungi, parasites, and human cellular elements

__ Fecal leukocyte examinations

__ Fern tests

__ Nasal Smears for granulocytes

__ Pinworm examinations

__ Post-coital direct, qualitative examinations of vaginal or cervical mucous

__ Potassium hydroxide (KOH) preparations

__ Qualitative semen analysis (limited to the presence/ absence of sperm and detection of motility)

__ Urine sediment examinations

Section 5. Other Licensure, Certification or Registration Information

Legal Owner Information–attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone #	Title

Section 6. Foreign Ownership

Does this facility have partial or full ownership by a foreign entity or foreign government? ☐ Yes ☐ No

If yes, what is the country of origin for the foreign entity? ____________________

Change of Ownership Information

Previous Name of Legal Owner		
Previous Name of Facility	Previous MTS License #	Effective Date of Ownership Change
Physical Address		
City	State	Zip Code

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

______________________________ ______________

Signature of Owner/Authorized Representative of Medical Test Site   Date

______________________________ ______________

Print Name   Print Title