



Provider Performed Microscopic Procedures (PPMP) Application Packet

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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
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 360-236-4985.

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. Indicate if you wish to retain the CLIA number if switching to a new license type.

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. Indicate if you wish to retain the CLIA number if changing ownership.

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.

You will receive a renewal notice for this license approximately 60 days before the expiration date. Please contact Customer Service at 360-236-4985 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>.

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

Revenue: 0420030000

Fee
<input type="checkbox"/> April 1, 2023 – June 30, 2025.....\$300.00

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust |

Section 1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
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Legal Owner/Operator Entity Name

Mailing Address

City	State	Zip Code	County
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Phone (enter 10 digit #)	Fax (enter 10 digit #)
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Email Address	Web Address
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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
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Facility Phone (enter 10 digit #)	Facility Fax (enter 10 digit #)
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Mailing Address (If different than physical address)

City	State	Zip Code	County
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For Office Use Only

Medical Test Site # _____ CLIA # _____

Section 2. Facility Specific Information

Site Type (check one only)

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

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 (CO₂) _____

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 360-236-4985.

Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Direct wet mount preparations for the presence or absence of bacteria, fungi, parasites, and human cellular elements | <input type="checkbox"/> Post-coital direct, qualitative examinations of vaginal or cervical mucous |
| <input type="checkbox"/> Fecal leukocyte examinations | <input type="checkbox"/> Potassium hydroxide (KOH) preparations |
| <input type="checkbox"/> Fern tests | <input type="checkbox"/> Qualitative semen analysis (limited to the presence/absence of sperm and detection of motility) |
| <input type="checkbox"/> Nasal Smears for granulocytes | <input type="checkbox"/> Urine sediment examinations |
| <input type="checkbox"/> Pinworm 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

If changing license type, do you want the facility to keep the already assigned CLIA number? Yes No

If yes, provide the CLIA number: _____

Change of Ownership Information

Previous Name of Legal Owner

Previous Name of Facility	Previous MTS License #	Effective Date of Ownership Change
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Physical Address

City	State	Zip Code
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If changing ownership, do you want the facility to keep the already assigned CLIA number? Yes No

If yes, provide the CLIA number: _____

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? _____

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