CY 2026 NON-DIAGNOSTIC GENERAL HEALTH ASSESSMENT REGISTRATION FORM

This registration form must be completed and received by the Humboldt County Public Health Laboratory at least 30 days prior to operating a program of non-diagnostic general health assessment (NGHA).

PART 1: ADMINISTRATION:

A. **Name of Organization or Operator:** _____

Permanent Address: _____

City: _____ ZIP Code: _____

Business Phone: ( ) _____ Fax: ( ) _____

CLIA Number: _____

B. **Name of Owner**: _____

Address if Different than Above: _____

City: _____ ZIP Code: _____

Business Phone: ( ) _____ Fax: ( ) _____

C. **Supervisory Committee Membership:**

Name of Physician: _____

Address: _____

City: _____ ZIP Code: _____

Business Phone: ( ) _____ Fax: ( ) _____

California Medical License Number: _____ Exp Date: _____

Name of Laboratory Technologist: _____

Address: _____

City _____ ZIP Code: _____

Business Phone: ( ) _____ Fax: ( ) _____

California Clinical Laboratory Scientist License Number: _____ Exp Date: _____

D. Record Storage

All operators must have a permanent address where records of testing and protocols shall be stored for the purpose of review for at least one year after testing has been completed. The Public Health Laboratory must be notified in writing within 30 days of any change in record storage.

Record Storage Address: _____

City: _____ ZIP: _____ Business Phone:( ) _____

PART 2: ASSESSMENT PROGRAM

A. Location Where Assessments Are to Be Performed (copy Part 2 for additional sites):

Name of Location: _____

Address: _____

City _____ Zip Code _____

Business Phone: ( ) _____ Fax: ( ) _____

B. Dates and Hours Program Will Be Operating at This Location:

Dates: _____ Hours: _____

Dates: _____ Hours: _____

Dates: _____ Hours: _____

NOTE: ANY CHANGES IN TIMES, DATES OR LOCATION MUST BE REPORTED IN WRITING TO THE HEALTH DEPARTMENT AT LEAST 24 HOURS PRIOR TO THE OPERATION OF THE PROGRAM:

C. Type or Kind of Non-Diagnostic Tests Being Conducted at This Location:

	Test, equipment name, and manufacturer:
__Total Cholesterol	_____
__High-Density Lipoprotein (HDL)	_____
__Low-Density Lipoprotein (LDL)	_____
__Triglycerides	_____
__Blood Glucose	_____
__Hemoglobin	_____
__Dipstick Urinalysis	_____
__Fecal Occult Blood	_____
__Urine Pregnancy	_____

__Other: _____

D. LIST OF EMPLOYEES: Please list all employees who will participate in the NGHAs at this location.

Name and Title	Authorized to perform skin puncture?
_____	Yes No
_____	Yes No
_____	Yes No
_____	Yes No
_____	Yes No
_____	Yes No

(Attach additional sheets if necessary)

NOTE: Please attach documentation of training to perform skin puncture for each individual listed above who will perform this procedure.

Complete a separate PART 2A for each additional location where assessments are to be performed.

PART 2A: ADDITIONAL ASSESSMENT PROGRAM LOCATION

Complete a separate PART 2A for each location where assessments are to be performed.

Name of organization _____

A. Location where NGHAs are to be performed:

Name of Location:			
Address:			
City:		ZIP	
Phone:		FAX	

B. Dates and Hours Program will operate at this location:

Date	Start Time	End Time

Note: Any changes in dates, times, or locations must be reported in writing to the Health Department at least 24 hours prior to the operation of the program.

C. Type of NGHA to be performed:

[ ] Blood Glucose
[ ] High-Density Lipoproteins (HDL)
[ ] Triglycerides
[ ] Other: Specify: _____
[ ] Total Cholesterol
[ ] Low-Density Lipoproteins (LDL)
[ ] Occult Blood

D. Testing Equipment to be used at this location:

Name of Equipment	Manufacturer

E. List of Employees:

Please list all employees who will participate in the nondiagnostic testing at this location:

Name	Title	Authorized to perform skin puncture?*	
		YES	NO

(Attach additional sheets if necessary)

*NOTE: Please attach documentation of authorization to perform puncture for each individual listed above who will perform this procedure. Include the name, signature, and California Medical License number of the Physician attesting. For licensed individuals please submit a copy of a valid license.

PART 3. COMPLIANCE

A. This assessment program must be operated per Section 1224 of the California Business and Professions Code. Please answer each of the following questions.

YES NO

[ ] [ ] 1. This program will be a non-diagnostic health assessment program, whose purpose will be to refer individuals to licensed sources of care as indicated.

[ ] [ ] 2. This program will utilize only those devices which comply with all of the following:

A. Meet applicable state and federal performance standards pursuant to Section 26605 of the Health and Safety Code.
B. Are not adulterated as specified in Article 2 (commencing with Section 26610) of Chapter 6 of Division 21 of the Health and Safety Code.
C. Are not misbranded as specified in Article 3 (commencing with Section 26630) of Chapter 6 of Division 21 of the Health and Safety Code.
D. Are not new devices unless they meet the requirements of Section 26670 of the Health and Safety Code.

[ ] [ ] 3. This program maintains a supervisory committee consisting of at a minimum, a California licensed physician and a clinical laboratory scientist licensed pursuant to the California Business and Professions Code.

[ ] [ ] 4. The supervisory committee for the program has adopted and signed written protocols which shall be followed in the program. (Please include a copy of your written protocols with the application).

[ ] [ ] 5. The protocols contain provision of written information to individuals to be assessed. (Please include a copy of any written information that you will provide individuals as part of this program).

[ ] [ ] 6. The written information to individuals includes the potential risks and benefits of assessment procedures to be performed in the program.

[ ] [ ] 7. The written information includes the limitations, including the non-diagnostic nature, of assessment examinations of biological specimens performed in the program.

[ ] [ ] 8. The written information includes information regarding the risk factors or markers targeted by the program.

[ ] [ ] 9. The written information includes the need for follow up with licensed sources of care for confirmation, diagnosis, and treatment as appropriate.

[ ] [ ] 10. The written protocols contain the proper use of each device utilized in the program including operation of analyzers, maintenance of equipment and supplies and performance of quality control procedures including the determination of both accuracy and reproducibility of measurements in accordance with instructions provided by the manufacturer of the assessment device used.

YES NO

[ ] [ ] 11. The written protocols contain the proper procedures to be employed when drawing blood, if blood specimens are to be obtained.

[ ] [ ] 12. The written protocols contain the proper procedures to be employed in handling and disposing of all biological specimens to be obtained and material contaminated by those biological specimens.

[ ] [ ] 13. The written protocols contain proper procedures to be employed in response to fainting, excessive bleeding, or other medical emergencies.

[ ] [ ] 14. The written protocols contain proper procedures for reporting of assessment results to the individual being assessed (Please attach a copy of your report form).

[ ] [ ] 15. The written protocols contain proper procedures for referral and follow up to licensed sources of care as indicated.

NOTE: The written protocols adopted by the supervisory committee shall be maintained for at least one year following completion of the assessment program during which period they shall be subject to review by state health department personnel and the local health officer or his or her designee, including the public health laboratory director.

B. If skin puncture to obtain a blood specimen is to be performed, please complete the following:

YES NO

[ ] [ ] 1. All individuals performing the skin puncture are authorized to do so under the Business and Professions Code.

[ ] [ ] 2. All individuals performing the skin puncture possess a statement signed by a California licensed physician and surgeon which attests that the named person has received adequate training in the proper procedure to be employed in skin puncture.

NOTE: Skin puncture means the collection of a blood specimen by the finger prick method only and does **not** include venipuncture, arterial puncture, or any other procedure for obtaining a blood specimen.

PART 4. FEES/REGISTRATION

A. Non-Refundable Annual Registration Fee: $104.

B. Licensee

Name of Person Requesting Registration: _____

Address if Different than Above: _____

City _____ Zip Code _____

Business Phone: ( ) _____ Fax: ( ) _____

Send:

- A completed application.
- Copies of Clinical Laboratory Improvements Amendments (CLIA) certificate, Clinical Laboratory Scientist current license, Physician's current medical license, and certificates for all staff in instrument training and fingerstick.
- Policies and procedures manual containing biohazard/medical waste disposal plan, quality control (QC) and quality assurance (QA) plans with supporting QC and QA logs, emergency medical plan, instrument procedure manual for each analyte, and patient education & referral information sheets.
- Any applicable fees.
- Applications may be submitted by either mail or email. However, applications will not be processed until the Public Health Laboratory receives a check for the fee. Make checks payable to the County of Humboldt. Send application by mail or email to:

  Mail: Humboldt County
  Public Health Fiscal
  PH Laboratory NGHA Program
  507 F St.
  Eureka, CA 95501

  Email: PHlabNGHAmailbox@co.humboldt.ca.us

I certify that the above information is accurate and complete, and that I am aware of the laws and regulations that apply to Non-Diagnostic Testing in the State of California and in the County/City in which testing is to be performed.

Signature of Applicant _____

Date of Application _____

Humboldt County
Public Health Laboratory

Reviewed By: _____ _____
Laboratory Director Date

Reviewed By: _____ _____
Health Officer Date

Registration Number: _____ Date Issued: _____

Fees Received: _____ Date Expires: _____