LABORATORY DIRECTOR'S AGREEMENT

Laboratory Director:

_____

Last Name First Name Middle Initial

Laboratory Director's New York State Department of Health Certification Qualification Number _____

Laboratory Information:

Laboratory Name _____
Address _____
_____
_____

New York State Department of Health Clinical Laboratory Permit number: _____
Out of State Laboratory Licensing Agency Document number: _____

I agree to assume the responsibilities, as defined by State and Federal laws, as the Laboratory Director of _____
I agree to notify the New York State Department of Health, Office of Health Insurance Programs, Fee for Service Provider Enrollment Bureau of any change of my Laboratory Director status.

Signature _____
(Laboratory Director)

Laboratory:

I understand enrollment in the New York State Medicaid Program of a Laboratory Director for my laboratory is a pre-condition for payment of Medicaid claims. Our laboratory solicits or accepts specimens for laboratory examinations or collects, processes or stores human blood or blood derivatives from:

Check Appropriate:
- ☐ Only Outside New York State
- ☐ Only Within New York State
- ☐ Both Outside and Inside New York State

Owner/Officer Name: _____
(Please print) (Title or Office)

Owner/Officer Signature: _____ Date: _____