

Laboratory Organization Update Form
Joint Commission on Accreditation of Healthcare Organizations

Please complete this form to update the Joint Commission on changes in your organization. We must receive this form within 30 days of the change. Please use your browser to print this form. Complete only the sections that apply to address the changes you are reporting. **The laboratory director whose name appears on the CLIA certificate must sign this notification.** Please mail the form to the address listed below.

***Please be advised that your state agency must also be notified of the following changes:**

- **Change in Certification Type**
- **Site (laboratory) Address/Name Change**
- **Ownership**
- **Laboratory Director**

Do not notify your state agency for the following changes related to a Certificate of Accreditation:

- **Addition or Deletion of Specialties/Sub-specialties**
- **Addition of Tests or Examinations**
- **Deletions or Changes in Test Methodologies**

Organization Information

Always complete this section

Joint Commission Healthcare Organization Identification Number: _____

Organization Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Lab Director's Name: _____

Lab Director's Signature: _____

Date: _____

Please indicate the type of change

- Discontinuation/Removal of a CLIA Identification Number from an Organization's Joint Commission Records**

CLIA Number: _____

Laboratory Name: _____

Address/Location: _____

City, State, Zip: _____

Effective Date: _____

Select a Reason for the Discontinuation of the CLIA Identification Number:

- Laboratory Closed
- Laboratory No Longer Performs Testing
- Laboratory Seeking non-Joint Commission accreditation
Name of Other Accrediting Organization: _____
- Laboratory Sold
- Other: _____

New Certificate of Accreditation CLIA Identification Number

CLIA Number: _____
Laboratory Name: _____
Address/Location: _____
City, State, Zip: _____
Effective Patient Testing Date: _____
Specialty(ies)/Subspecialty(ies) Performed: _____

Proficiency Test Provider(s): _____
Estimated Annual Test Volume: _____

New Certificate for Provider Performed Microscopy Procedures CLIA Identification Number

CLIA Number: _____
Laboratory Name: _____
Address/Location: _____
City, State, Zip: _____
Test(s) Performed: _____

New Certificate of Waiver CLIA Identification Number

CLIA Number: _____
Laboratory Name: _____
Address/Location: _____
City, State, Zip: _____
Test(s) Performed: _____

***Change in Certification Type**

CLIA Number: _____
Laboratory Name: _____
Address/Location: _____
City, State, Zip: _____
Effective Date: _____

Change from:

- Certificate of Waiver
- Certificate for Provider Performed Microscopy Procedures
- Certificate of Compliance
- Certificate of Accreditation

Change to:

- Certificate of Waiver
- Certificate for Provider Performed Microscopy Procedures
- Certificate of Compliance
- Certificate of Accreditation

If changing to a Certificate of Waiver or Provider Performed Microscopy Procedures, please complete the information below:

Test(s) Performed: _____

If changing to a Certificate of Accreditation, please complete information below:

Specialty(ies)/Subspecialty(ies) performed: _____

Proficiency Test Provider(s): _____
Estimated Annual Test Volume: _____

Add Specialty(ies)/Subspecialty(ies) to an existing Certificate of Accreditation CLIA Identification Number

CLIA Number: _____
Laboratory Name: _____
Address/Location: _____
City, State, Zip: _____
Effective Patient Testing Date: _____
Additional Specialty(ies)/Subspecialty(ies): _____
Proficiency Test Provider(s): _____
Estimated Annual Test Volume: _____

Delete Specialty(ies)/Subspecialty(ies) from an existing Certification of Accreditation CLIA Identification Number

CLIA Number: _____
Laboratory Name: _____
Address/Location: _____
City, State, Zip: _____
Effective Date: _____
Deleted Specialty(ies)/Subspecialty(ies): _____

***Site (laboratory) Address/Name Change**

CLIA Number: _____
New Name: _____
New Address: _____
City, State, Zip: _____
Effective Date: _____

***Ownership Change**

CLIA Number: _____
Current Owner: _____
New Owner: _____
Effective Date: _____

***Laboratory Director Change**

Complete this section ONLY if change is related to a Certificate of Accreditation

CLIA Number: _____
Current Laboratory Director: _____
New Laboratory Director: _____
Effective Date: _____

Please use company letterhead to provide details of the following changes:

- Test or examination within a specialty or subspecialty area that is not included in the laboratory's accreditation, including effective date.
Notification required ONLY if change is related to a Certificate of Accreditation
- Deletions or changes in test methodologies for any test or examination included in a specialty or subspecialty, or both, including effective date.
Notification required ONLY if change is related to a Certificate of Accreditation

Please mail your updates within 30 days of the change to:

Joint Commission on Accreditation of Healthcare Organizations

Attn: Accreditation Operations/Service Team (Indicate service team from the list below)

**One Renaissance Boulevard
Oakbrook Terrace, IL 60181**

- **Service Team Corporate (Multihospital System)**

If you are not part of a multihospital system, select your state and region from this list:

- **Service Team East Region: CT, DC, DE, FL, GA, GU, MA, MD, ME, NC, NH, NJ, NY, PA, PR, RI, SC, TX, VA, VT, VI, Paris, France**
- **Service Team Central Region: AL, AR, IA, IL, IN, KY, LA, MI, MO, MS, OH, TN, WI, WV**
- **Service Team West Region: AK, AZ, CA, CO, HI, ID, KS, MN, MT, ND, NE, NM, NV, OK, OR, SD, UT, WA, WY**

For office use only:

Date Updated: _____

Initials: _____

Acknowledged Date: _____

Initials: _____