

### SURVEY REPORT FORM (CLIA)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0544. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

#### SURVEYOR INSTRUCTIONS FOR CMS 1557

- For **specialty(ies)/subspecialty(ies) added or deleted**: Use the space provided to list corresponding information and effective dates.
- For **proficiency testing**: Any comments pertinent to the survey or determination of compliance can be listed here.
- Each surveyor must **sign the certifying statement** on page 2 for each type of survey conducted (*see "survey status;" "other" may include follow-up visit to verify a POC*).

#### GENERAL INFORMATION

CLIA IDENTIFICATION NUMBER	DATE OF SURVEY		
LABORATORY NAME	TELEPHONE NUMBER ( <i>include area code</i> )		
LABORATORY ADDRESS ( <i>number, street</i> )	CITY	STATE	ZIP
MAILING ADDRESS ( <i>if different from above</i> )	CITY	STATE	ZIP
NAME OF DIRECTOR <i>last</i>	<i>first</i>	<i>MI</i>	
SURVEY STATUS: ( <i>Check all that apply</i> )		STATE/COUNTY CODE	STATE REGION CODE
<input type="checkbox"/> Initial Certification	<input type="checkbox"/> State Exemption ( <i>State</i> ) _____	STATE LICENSE NUMBER ( <i>if applicable</i> )	
<input type="checkbox"/> Recertification	<input type="checkbox"/> Accreditation ( <i>Organization</i> ) _____		
<input type="checkbox"/> Validation	<input type="checkbox"/> Addition of (Sub)Specialty(ies)	MEDICARE PROVIDER NUMBER(S)	
<input type="checkbox"/> Complaint	<input type="checkbox"/> Other ( <i>Specify</i> ) _____	_____	
		_____	
		_____	

#### PERSONNEL: SHOW NUMBER OF PEOPLE QUALIFIED UNDER EACH APPLICABLE REGULATORY SECTION

<b>DIRECTOR MODERATE COMPLEXITY 493.1405(a) and</b>  (b)(1) _____ (6) _____ (2) _____ (7) _____ (3) _____ ( ) _____ (4) _____ ( ) _____ (5) _____ ( ) _____	<b>CLINICAL CONSULTANT MODERATE COMPLEXITY 493.1417</b>  (a) _____ (b) _____ ( ) _____ ( ) _____	<b>TECHNICAL CONSULTANT MODERATE COMPLEXITY 493.1411(a) and</b>  b) (1) _____ ( ) _____ (2) _____ ( ) _____ (3) _____ (4) _____	
<b>DIRECTOR HIGH COMPLEXITY 493.1443(a) and</b>  (b)(1) _____ ( ) _____ (2) _____ ( ) _____ (3) _____ (4) _____ (5) _____	<b>CLINICAL CONSULTANT HIGH COMPLEXITY 493.1455</b>  (a) _____ (b) _____ ( ) _____ ( ) _____	<b>TECHNICAL SUPERVISOR HIGH COMPLEXITY 493.1449(a) and</b>  (b) _____ (h) _____ (n) _____ (c) _____ (i) _____ (o) _____ (d) _____ (j) _____ (p) _____ (e) _____ (*) _____ (q) _____ (f) _____ (l) _____ ( ) _____ (g) _____ (m) _____ ( ) _____	<b>GENERAL SUPERVISOR HIGH COMPLEXITY 493.1461(a) and</b>  (b)(1) _____ (d)(1) _____ (b)(2) _____ (d)(2) _____ (c)(1) _____ (d)(3) _____ (c)(2) _____ (e) _____ (c)(3) _____ ( ) _____
	<b>CYTOTECHNOLOGIST 493.1483(a) and</b>  (b)(1) _____ (4) _____ (2) _____ (5) _____ (3) _____ ( ) _____	<b>TECHNICAL SUPERVISOR CYTOLOGY *493.1449(a) and</b>  (k)(1) _____ ( ) _____ (2) _____ ( ) _____	<b>GENERAL SUPERVISOR CYTOLOGY 493.1469</b>  (a) _____ ( ) _____ (b) _____ ( ) _____

SPECIALTIES/SUBSPECIALTIES	ACCREDITED PROGRAM	ANNUAL TEST VOLUMES	(SUB)SPECIALTY(IES) ADDED EFFECTIVE DATE	(SUB)SPECIALTY(IES) DELETED EFFECTIVE DATE	PROFICIENCY TESTING
010 <input type="checkbox"/> Histocompatibility A <input type="checkbox"/> Transplant B <input type="checkbox"/> Nontransplant	_____	_____	_____	_____	NA
100 <input type="checkbox"/> Microbiology 110 <input type="checkbox"/> Bacteriology 115 <input type="checkbox"/> Mycobacteriology 120 <input type="checkbox"/> Mycology 130 <input type="checkbox"/> Parasitology 140 <input type="checkbox"/> Virology 150 <input type="checkbox"/> Other	_____	_____	_____	_____	_____
200 <input type="checkbox"/> Diagnostic Immunology 210 <input type="checkbox"/> Syphilis Serology 220 <input type="checkbox"/> General Immunology	_____	_____	_____	_____	_____
300 <input type="checkbox"/> Chemistry 310 <input type="checkbox"/> Routine 320 <input type="checkbox"/> Urinalysis 330 <input type="checkbox"/> Endocrinology 340 <input type="checkbox"/> Toxicology 350 <input type="checkbox"/> Other	_____	_____	_____	_____	_____
400 <input type="checkbox"/> Hematology	_____	_____	_____	_____	_____
500 <input type="checkbox"/> Immunohematology 510 <input type="checkbox"/> ABO Group & Rh Type 520 <input type="checkbox"/> Antibody Detection (transfusion) 530 <input type="checkbox"/> Antibody Detection (nontransfusion) 540 <input type="checkbox"/> Antibody Identification 550 <input type="checkbox"/> Compatibility Testing 560 <input type="checkbox"/> Other	_____	_____	_____	_____	_____
600 <input type="checkbox"/> Pathology 610 <input type="checkbox"/> Histopathology 620 <input type="checkbox"/> Oral pathology 630 <input type="checkbox"/> Cytology	_____	_____	_____	_____	NA NA
800 <input type="checkbox"/> Radiobioassay	_____	_____	_____	_____	NA
900 <input type="checkbox"/> Clinical Cytogenetics	_____	_____	_____	_____	NA

Are immunohematology tests performed for transfusion purposes? .....  Yes  No

Are blood and/or blood products (including autologous) collected? .....  Yes  No

For a partial survey (validation, addition of (sub)specialty, complaint, or follow-up) list the laboratory condition(s) regulation number(s) reviewed:

_____	_____	_____
_____	_____	_____
_____	_____	_____

In accordance with current survey procedures, this laboratory was found to be in compliance with program requirements.

SIGNATURE	DATE
SIGNATURE	DATE
SIGNATURE	DATE

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## SURVEY WORKSHEET (CLIA)

PAGE \_\_\_\_\_ OF \_\_\_\_\_

NAME OF SURVEYOR	DATE OF SURVEY (MMDDYY)
NAME OF FACILITY	CLIA IDENTIFICATION NUMBER

