

**INSTRUCTIONS:** Please refer to separate instruction forms. Complete all applicable sections of form, attach requested documents, and mail, fax [(518) 485-5568], or email ([ELAP@health.state.ny.us](mailto:ELAP@health.state.ny.us)) the document.

*For office use only*

LAB ID: \_\_\_\_\_

TYPE: G \_\_\_\_\_ I \_\_\_\_\_ C \_\_\_\_\_

**Section A: General Information**

LABORATORY NAME \_\_\_\_\_

US EPA LAB CODE \_\_\_\_\_ (Applies to labs testing NW and/or PW samples)

PRIMARY ACCREDITING AUTHORITY (if other than New York)  
 \_\_\_\_\_

FEDERAL EMPLOYER ID \_\_\_\_\_

Is the application request for NYS work (i.e, will analysis be performed on NYS samples)? (*New applications only*) \_\_\_ Y \_\_\_ N

**OWNER TYPE**

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> Municipal | <input type="checkbox"/> Private                     | <input type="checkbox"/> Publicly Owned Corporation |
| <input type="checkbox"/> County    | <input type="checkbox"/> Partnership                 | <input type="checkbox"/> Public Benefit Corporation |
| <input type="checkbox"/> State     | <input type="checkbox"/> Chapter S Corporation       | <input type="checkbox"/> Governmental Corporation   |
| <input type="checkbox"/> Federal   | <input type="checkbox"/> Privately Owned Corporation | <input type="checkbox"/> If Other, please specify.  |

Lab telephone number (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Lab FAX number (\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

Lab e-mail address \_\_\_\_\_

Quality Manual enclosed (all new applications) and most recent Assessment Report and Response (new secondary applications only)

VIN Number (Mobile laboratories only) \_\_\_\_\_

**HOURS OF OPERATION** - Please indicate days in operation and enter business hours.

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
From:							
To:							

**Laboratory Location Address**

Number & Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ - \_\_\_\_\_

NYS County \_\_\_\_\_ Country \_\_\_\_\_

**Mailing Address** if different from laboratory location

Number & Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ - \_\_\_\_\_

NYS County \_\_\_\_\_ Country \_\_\_\_\_

**Billing Address** if different from laboratory location

Number & Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ - \_\_\_\_\_

NYS County \_\_\_\_\_ Country \_\_\_\_\_

Please provide name of **Accounts (Payable) Manager**. \_\_\_\_\_

**Owner Information**

Owner's Name: \_\_\_\_\_

Number & Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ - \_\_\_\_\_

NYS County \_\_\_\_\_ Country \_\_\_\_\_

Are there additional owners of 10% or more? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide a list of all additional owners on a separate sheet and attach it to this application.

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**LABORATORY CLASSIFICATION** (Check only those that are applicable.)

- |  |   |
|--|---|
| <input type="checkbox"/> Water Treatment Facility      | <input type="checkbox"/> Hospital or Health Care Facility |
| <input type="checkbox"/> Sewage Treatment Facility     | <input type="checkbox"/> Mobile Laboratory                |
| <input type="checkbox"/> Industrial Waste Treatment    | <input type="checkbox"/> Academic Laboratory              |
| <input type="checkbox"/> Commercial or fee for service | <input type="checkbox"/> Other (describe) _____           |

**Section B: Laboratory Personnel**

Attach copies of pages 3 and 4 as necessary for each person designated to a specific role listed below. Please specify the area you will be directing next to the lead technical director or technical director.

1. PERSONNEL APPROVAL (Check approval requested.)

- |   |   |
|---|---|
| <input type="checkbox"/> Lead Technical Director _____            | Title (Select only one.)                                    |
| <input type="checkbox"/> Technical Director (if applicable) _____ | <input type="checkbox"/> Ph.D. <input type="checkbox"/> Ms. |
| <input type="checkbox"/> Quality Assurance (QA) Officer           | <input type="checkbox"/> M.D. <input type="checkbox"/> Mr.  |
| <input type="checkbox"/> Critical Agents Analyst                  | <input type="checkbox"/> Other _____                        |
| <input type="checkbox"/> ADS Operator                             |   |

Name \_\_\_\_\_ Email Address \_\_\_\_\_  
 Required for Lead Technical Director HCS Access (Month/day of birth) \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ --- \_\_\_\_\_ Extension No. \_\_\_\_\_

Hours On-Site - Indicate work hours.

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
From:							
To:							

2. COMPETENCE held by Personnel listed in Section B.1. (Check the one(s) that is(are) most applicable.)

- |  |  |
|--|--|
| <input type="checkbox"/> 2 yrs College + 16 Credits Chemistry                          | <input type="checkbox"/> QA/QC Documented Training/Experience                |
| <input type="checkbox"/> 4 yrs College + 24 Credits Chemistry                          | <input type="checkbox"/> Radiochem – 4 yrs College + 24 Credits Chemistry    |
| <input type="checkbox"/> 4 yrs College + 16 Credits Biology includes Micro and/or WETT | <input type="checkbox"/> Radon – 2 yrs College                               |
| <input type="checkbox"/> Industrial Treatment Plant Operator                           | <input type="checkbox"/> Radon (CRM) – H.S. Diploma + Specialized Course     |
| <input type="checkbox"/> Microbiology Critical Agents Analyst                          | <input type="checkbox"/> Sewage Treatment Plant Operator License             |
| <input type="checkbox"/> 2 yrs College + 4 Credits in Microbiology                     | <input type="checkbox"/> Asbestos (TEM) – 4 yrs College + Specialized Course |
| <input type="checkbox"/> Asbestos (PLM) – 2 yrs College + Specialized Course           | <input type="checkbox"/> Drinking Water Treatment Plant Operator License     |
| <input type="checkbox"/> Fibers (PCM) – 2 yrs College + Specialized Course             | <input type="checkbox"/> ADS Documented Training/Experience                  |

3. LABORATORY CONTACT PERSON

Name \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ --- \_\_\_\_\_ Extension No. \_\_\_\_\_

4. HEALTH PROVIDER NETWORK (HPN) CONTACT PERSON -This person will have access to the secure DOH website application, where assessment reports, invoices and annual renewal application are posted.

Name \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ --- \_\_\_\_\_ Extension No. \_\_\_\_\_

Email Address \_\_\_\_\_ Month/Day of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Complete this page for each individual with credential requirements.

5. EDUCATION							
Attach a appropriate degree, diploma, certificate, and/or transcript of grades to a application.							
Name and location (City, State, and Country) of institution.	Period Attended		Major	Total semester credit hours			Degree, diploma or certificate awarded  Mo/Yr Awarded
	From Mo/Yr	To Mo/Yr		Chemistry	Microbiology	Biology	

6a. OPERATOR'S CERTIFICATE (if applicable)  
 Attach copy of Operator's Certificate to application.  
 Sewage Treatment Plant  
 Drinking Water Treatment Plant  
 ADS Operator

6b. CLINICAL LABORATORY (if applicable)  
 Indicate PFI No. \_\_\_\_\_

7. ENVIRONMENTAL LABORATORY EXPERIENCE				Indicate experience in number of months.											
Name and location (City, State, and Country) of laboratory and/or institution. Any gaps in employment will be assumed to be non-environmental laboratory work periods.	Period Employed		Position(s) held	PCM	PLM	TEM	Quality Assurance	Inorganic Chemistry	Organic Chemistry	Radiochemistry	Radon in Air	Microbiology	Critical Agents	WETT	ADS
	From Mo/Yr	To Mo/Yr													

I certify that the information provided in this document is complete, true, and correct, and that providing false information is a basis for revocation of the laboratory's Certificate of Approval. I further understand that offering a false instrument is a crime under the New York State Penal Law.

Applicant's Printed Name \_\_\_\_\_ Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Certification of Compliance**

Has any corporate shareholder or technical director ever had charges of administrative violations of local, state or federal laws, rules and regulations sustained against himself/herself?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, please provide details on a separate sheet and attach to this form.

Has any corporate shareholder or technical director ever been convicted of any crime or offense related to the furnishing of or billing for environmental laboratory services or environmental remediation services or sample collection related thereto, which is considered an offense involving theft, fraud, or offering a false instrument?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, please provide details on a separate sheet and attach to this form.

The undersigned understand and acknowledge that the laboratory is required to be in continual compliance with New York State's Environmental Laboratory Approval Program (ELAP) standards and is subject to the penalty provisions of the Program. I understand that under Section 55-2.6 of 10 NYCRR, a Certificate of Approval may be revoked, suspended, or denied if any fact is misrepresented in this application, including failure to notify ELAP regarding changes of ownership. Changes in any of the information in this application must be reported to ELAP immediately. I also understand that additional penalties may apply if I misrepresent, conceal, or fail to disclose facts or information regarding initial or continuing eligibility for a Certificate of Approval, including conviction of any crime related to the provision of or billing for laboratory services, omission or misrepresentation of material facts related to the operation of an environmental laboratory, or the concealment of ownership or controlling interest. I further understand that offering a false instrument constitutes a crime under the Penal Law of the State of New York.

It is certified that: the laboratory will operate in accordance with Section 502 of the Public Health Law; the owner or technical director will monitor and document the use of approved methods; records will be maintained as prescribed in the ELAP Quality Systems Standard; and the owner or technical director will notify ELAP if the laboratory is found to be in violation of any federal, state, or local law by the federal, state, or local agency enforcing that law; laboratory staff will permit authorized department employees to conduct announced or unannounced on-site assessments and investigations and will allow copies of any laboratory records to be taken by authorized department employees; the laboratory management will notify any other states in which the laboratory is accredited if the laboratory's New York ELAP accreditation is revoked or suspended in whole or in part; and the laboratory management will similarly notify New York ELAP if the laboratory's accreditation is revoked or suspended in whole or in part by any other state accrediting authority.

Under the New York State Workers Compensation Law, businesses applying for permits or licenses issued by the State must hold worker's compensation and disability benefits coverage or document their qualifying for an exception. Information regarding this requirement and the process for submitting proof of enrollment can be found in the *New York State Workers Compensation Board Employers Handbook – A Guide to the Worker's Compensation System for the New York State Business Owner*, available at [http://www.wcb.state.ny.us/content/main/Small\\_Business/employer\\_handbook.pdf](http://www.wcb.state.ny.us/content/main/Small_Business/employer_handbook.pdf).

By signing as owner, I hereby certify that I am the owner of the laboratory named in this application and that there are no misrepresentations in my answers to the questions on this application. By signing as the owner representative, I attest that I am authorized to sign on behalf of the owner named in this application.

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Name of Owner (printed)

\_\_\_\_\_  
Date

Or

\_\_\_\_\_  
Signature of Owner Representative

\_\_\_\_\_  
Name / Title of Owner Representative (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Lead Technical Director

\_\_\_\_\_  
Name of Lead Technical Director (printed)

\_\_\_\_\_  
Date