ISDH Acute Care Division
CLIA Certification Program

ENCLOSURE A

DISCLOSURE OF OWNERSHIP REQUIRED INFORMATION

*****Facility (Legal Business Name): _____

*****DBA (Doing Business As name): _____

CLIA #: _____ (if assigned) Current EIN #: _____

I. Provide a copy of the IRS letter of assignment of your Employer Identification Number (EIN) or tax ID (TIN) showing the 9-digit number, e.g., 12-3456789.

II. Type of Entity:

For Profit	Non-Profit	Government
☐ Individual	☐ Church Related	☐ State
☐ Partnership*	☐ Individual	☐ County
☐ Corporation*	☐ Partnership*	☐ City
☐ Limited Liability	☐ Corporation*	☐ City/County
☐ Company*	☐ Limited Liability Company*	☐ Hospital District
☐ Other *(specify)*	☐ Other *(specify)*	☐ Federal
		☐ Other *(specify)*

Provide the appropriate form signed by the Indiana Secretary of State:

- If a Limited Partnership, submit a copy of the "Application for Registration" and Certificate of Registration" signed by the Indiana Secretary of State.
- If a Corporation, submit a copy of the "Articles of Incorporation" and "Certification of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.
- If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

III. Other Identifying Information

Current Owner Name(s)	Address	Phone #

IV. Has the Director or Owner ever had CLIA certification suspended or revoked? □ Yes □ No
(*If yes, state on a separate sheet the facts of each case completely and concisely)*

V. Officers/Directors/Members/Partners/Managers:

List all individuals/persons associated with the applicant entity and indicate the individuals title (i.e., officer, director, member, partner, etc.) If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Name	Title	Business Address	Phone Number

VI. Are any individuals/persons associated with applicant entity (listed above) also associated with any other entity operating laboratories in Indiana or any other states? □ Yes □ No

If "yes", list names and addresses of facilities owned by each individual. *(use additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

VII. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? □ Yes □ No

If yes, list each facility (or affiliated facility) and explain the relationship. (use additional sheet if necessary)

Facility/Affiliated facility	Relationship

VIII. Certification/Operating History

Are any of the individuals associated with or have been associated with, any other facility that is operating, or has operated laboratories in Indiana or any other state that had a facility's certification revoked, suspended or denied? ☐ Yes ☐ No

(If yes, provide the name of facility, state, type of actions and date(s))

Facility	State	Type of Actions	Date(s)

IX. I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color, creed or national origin.

IF SIGNED BY ANY INDIVIDUAL (e.g., THE ADMINISTRATOR) OTHER THAN INDICATED BELOW, AN AFFIDAVIT SHOULD BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/OWNER OR DIRECTOR.

Name of Authorized Representative (Printed)	Title
Signature	Date