Oklahoma State Department of Health
Protective Health Services
Medical Facilities
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102
Telephone: (405) 426-8470
FAX: (405) 990-7559

APPLICATION FOR LICENSE TO OPERATE A DRUG AND/OR ALCOHOL TESTING FACILITY

INSTRUCTIONS

I. Read carefully and complete all portions of the application. Please print or type.

II. Application for license shall be made by the director of the testing facility. Any changes are to be reported promptly to the address above.

III. A separate application shall be completed for:

(a) Each testing facility location (a facility that moves from testing site to testing site shall indicate the address of its primary site);

(b) Each van or other mobile unit providing laboratory services.

IV. Any changes are to be reported promptly to the address below.

V. **The License FEE for each testing facility shall be $150.00 annually and must accompany the application. Both should be submitted directly to Financial Management at the post office box listed below.** Please do not submit fees to the Medical Facilities Division. Checks, money orders or bank drafts must be made payable to OKLAHOMA STATE DEPARTMENT OF HEALTH, must clearly identify the facility which the payment is associated and be mailed to:

Financial Management - Receipting Unit
Oklahoma State Department of Health
P.O. Box 268823
Oklahoma City, OK 73126-8823

Class of License (check **all** applicable classes performed):

□ **Initial Drug Screening:**
□ Urine □ Blood □ Saliva □ Hair

□ **Confirmatory Drug Testing**

□ **Initial Alcohol Screening:**
□ Breath □ Saliva □ Blood □ Urine

□ **Confirmatory Alcohol Testing**

1. **Operating Entity (Legal Name):** **License No.** _____

_____

2. **Doing Business as Name (DBA):**

_____

3. **Finding Address:**

_____ **Tel. No.** ( ) _____-_____
(Number & Street)

_____ **Fax No.** ( ) _____-_____
(City) (State) (Zip)

4. **Mailing Address:**

_____
(Number & Street)

_____
(City) (State) (Zip)

5. **Name of Director:**

_____

5A. Screening laboratories must provide the following: Attach as an enclosure and number the response (5A).

(a) Names and qualifications of all technical staff in accordance with 310:638-5-2;

(b) Name and qualification of Director in accordance with 310:638-5-2 (1) (A) (B):

(1) **Director.** The drug screen testing facility shall have a qualified individual to assume professional, organizational, educational, and administrative responsibility for the drug screen testing facility. The director shall possess the following minimum qualifications:
(A) A bachelor's degree from an accredited institution in the chemical, biological, or physical sciences or medical technology; and
(B) Subsequent to graduation have had two (2) or more years of full-time drug testing experience.

(b) Proof of enrollment and satisfactory performance in an approved proficiency testing program; and

(c) Name and address of the testing facility(ies) utilized for confirmation testing.

OR

5B. Facilities seeking licensure based on certification by the United States Department of Health and Human Services or accreditation by the College of American Pathologists must submit proof of current certification or accreditation. Attach such proof as an enclosure and number the response (5B).

8. Hours of Operation:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From (AM):							
To (PM):							

Mobile facilities should include a schedule of testing locations. If a schedule is not available or unknown at the present time, please include a telephone number, email address, or other information we may use to contact the facility to arrange for inspection.

6. SIGNATURE OF DIRECTOR: *The undersigned hereby makes application for license to operate a drug and/or alcohol testing facility subject to the provisions of the Oklahoma Statutes and to the regulations adopted thereunder by the State Board of Health:*

Signature: _____

Printed Name: _____

Director's Email address: _____

Date: _____

7. AFFIDAVIT

STATE OF _____ County of _____ On this _____ day of _____, personally appeared before me _____

whose identity is personally known to me (or proved to me on the basis of satisfactory evidence) and who by me duly sworn (or affirmed), did say that to the best of his/her knowledge and belief, the statements in the foregoing application are true and correct and the he/she acknowledged the he/she executed it.

Subscribed and sworn to before me _____
(Notary Public)

My commission expires: ____/____/____

QUESTIONNAIRE

Mark the box for each drug/metabolite tested in your laboratory and indicate the methodology used for screening and/or confirmatory testing. Please return the completed questionnaire along with your drug and alcohol testing application.

FACILITY NAME:

DRUG/METABOLITE	SCREENING METHOD	CONFIRMATORY METHOD
o Alcohol		
o Marijuana		
o Cocaine		
o Codeine		
o Hydrocodone		
o Hydromorphone		
o Meperidine		
o Methadone		
o Oxycodone		
o Propoxyphene		
o Herion		
o Morphine		
o Phencyclidine		
o Amphetamines		
o Methamphetamines		
o Methylenedioxyamphetamine		
o Methylenedioxymethamphetamine		
o Phentermine		
o Amobarbital		
o Butalbital		
o Pentobarbital		
o Secobarbital		
o Diazepam		
o Chlordiazepoxide		
o Alprazolam		
o Clorazepate		
o Methaqualone		

Please indicate any other drugs/metabolites for which you do testing:

_____

_____