New Jersey Department of Health
Clinical Laboratory Improvement Services
P. O. Box 361
Trenton, NJ 08625-0361

http://www.nj.gov/health/phel/clinical-lab-imp-services/

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

SECTION A - IDENTIFYING INFORMATION

1. Name of Entity	2. EIN/Federal Tax ID No.
Doing Business As (DBA):	3. County
4. Street Address	5. Telephone No.
6. City, State, Zip Code	7. How many owners have an ownership interest in this entity?

8. Type of Entity

☐ Sole Proprietorship ☐ Corporation ☐ Other (Specify): _____

☐ Partnership ☐ Unincorporated Associations

SECTION B - FOR EACH OWNER, COMPLETE THIS SECTION. IF MORE THAN ONE OWNER, COPY AND COMPLETE THIS SECTION FOR EACH.

1. Owner Name (First)	(Middle)	(Last)	Jr., Sr., etc.	M.D., D.O., etc.

2. Effective Date of Ownership	3. Date of Birth (MM/DD/YY)

4. County of Birth	5. State of Birth	6. Country of Birth

7. Does this owner now have or has this owner ever had ownership in a clinical laboratory in this or any other state?

☐ Yes ☐ No

If Yes, supply all current and prior information requested below for all applicable entities. (Attach additional sheets if necessary.)

8. Organization's Legal Business Name

9. Employer Identification Number	10. Dates Associated (MM/DD/YY) From: To:

SECTION C - ADVERSE LEGAL ACTIONS

1. Check if this owner has ***EVER*** had any of the following adverse legal actions imposed by the State of New Jersey or by any other state or federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "None of These" box. Attach copy of adverse legal action notification.

☐ Administrative Sanctions	_____	Health Care Related:	
☐ Program Exclusion(s) *	_____	☐ Criminal Fine(s)	_____
☐ Suspension of Payment(s) *	_____	☐ Pending Civil Judgment(s)	_____
☐ Civil Monetary Penalty(ies)	_____	☐ Pending Criminal Judgment(s)	_____
☐ Assessment(s)	_____	☐ Judgment(s) Pending under	
☐ Program Debarment(s) *	_____	the False Claims Act	_____

* New Jersey Medical Assistance and Health Services (Medicaid); New Jersey Family Care/Kid Care; Medicare; Work First New Jersey/General Assistance.

☐ None of These

2. Does this owner have any outstanding criminal fines?	3. Does this owner have any outstanding restitution orders?
☐ Yes ☐ No	☐ Yes ☐ No
4. Has this owner ever been convicted of any health care related crime?	5. Has this owner ever been convicted of a felony under Federal or State law?
☐ Yes ☐ No	☐ Yes ☐ No

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST
(Continued)

1. Name of Entity	2. EIN/Federal Tax ID No.

SECTION D - CHANGE IN OWNERSHIP/CONTROL

1. Has there been a change in ownership or control within the last year?	2. Do you anticipate any change in ownership or control within the year?	3. Do you anticipate filing for bankruptcy within the year?
☐ Yes ☐ No If yes, give date: _____	☐ Yes ☐ No If yes, when? _____	☐ Yes ☐ No If yes, when? _____

4. Is this facility operated by a management company or leased in whole or in part by another organization?	5. Has there been a change in Administrator or Laboratory Director within the last year?
☐ Yes ☐ No If yes, give date of change in operations: _____	☐ Yes ☐ No

SECTION E - CERTIFICATION

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial, revocation or suspension of licensure.

We the undersigned certify that all of the information given on this application and on the accompanying attachments is true, correct and complete as of this date and that notification, by certified mail, or any change(s) will be made within 14 days of such change(s).

We further certify that testing will not be performed unless all applicable State and Federal certificates, licenses and required approvals are maintained.

Name of Authorized Representative (Print or type)	Title

Signature	Date