BRITISH COLUMBIA | Ministry of Health

Laboratory Services

HLTH 1952
NOTIFICATION OF CHANGE TO A LABORATORY AND/OR SPECIMEN COLLECTION FACILITY

Under the *Laboratory Services Act*

IMPORTANT APPLICANT INFORMATION

In accordance with Part 3(10) of the Laboratory Services Regulation, the operator, or Medical Director, of a laboratory facility must notify the Ministry at least 30 days before any changes are made to any of the following:

- medical directorship and/or laboratory physician staff (facility or regional)
- operator contact information
- hours of operation
- the addition or removal of a bed/stretcher and/or phlebotomy chair
- withdrawal of operational services (categories or tests)
- temporary or permanent closure of a laboratory or specimen collection facility
- the addition or cancellation of a payment number
- a specimen collection station's receiving and testing laboratory
- shareholder and/or ownership percentages

HOW TO COMPLETE AND SUBMIT THIS APPLICATION

This completed form with enclosures and any attachments must be signed by an authorized representative of the private or public organization and submitted via the laboratory services secure upload tool located at:
http://www.gov.bc.ca/labservicesupload

Only complete forms will be accepted for processing.

For assistance in completing this form, please read Part 2.3 of the Policies and Guidelines, located at:
https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/laboratory-services/facilities_approvals_policy.pdf

Personal information on this form is collected under the authority of s.26 (1) of the *Laboratory Services Act* and will be used to update your approval to provide benefits under the *Laboratory Services Act* and for record keeping. This information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act or the *Laboratory Services Act*. If you have any questions about the collection of this information, please contact Laboratory Services at: labservices@gov.bc.ca.

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Date of Notification (YYYY / MM / DD)	Date of Change (YYYY / MM / DD)

TYPE OF CHANGE

Please indicate the reason for submitting this form by selecting all applicable boxes below and completing the corresponding parts of the form.

If additional space is required, include an attachment upon submission of this form.

- ☐ A. Medical Directorship and/or Laboratory Physician Staff
- ☐ B. Operator Contact Information Change
- ☐ C. Hours of Operations
- ☐ D. Beds/Stretchers, Phlebotomy Chairs & Equipment
- ☐ E. Withdrawal of Services
- ☐ F. Closure – Temporary or Permanent
- ☐ G. Payment Number – Addition or Cancellation
- ☐ H. Receiving Laboratory
- ☐ I. Shareholders

FACILITY INFORMATION

Organization type

☐ Publicly Owned ☐ Privately Owned

Facility Name	Facility Number	Associated Payee Number

Facility Location (street address, city, postal code)

Services

☐ Laboratory – testing only ☐ Laboratory – specimen collection and testing ☐ Specimen collection only

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PART A – MEDICAL DIRECTORSHIP AND LABORATORY PHYSICIAN STAFF

MEDICAL DIRECTORSHIP

Please provide the name and details of both the preceding and succeeding laboratory Medical Directors. The Medical Director is the person with the responsibility for, and authority over, the laboratory.

For facility-based laboratory Medical Directors, indicate the facility name and number that the succeeding Medical Director will be responsible for.
For regional Medical Directors, attach a list of facility names the succeeding regional Medical Director will be responsible for.

If further space is required, please attach an additional document to this form.

Please indicate if the Medical Directorship change is regional or facility-based:

☐ **Regional Medical Director** ☐ **Facility-based Medical Director**

PRECEDING MEDICAL DIRECTOR INFORMATION	SUCCEEDING MEDICAL DIRECTOR INFORMATION
Name	Name
MSP Number	MSP Number
Email	Email
End Date (YYYY / MM / DD)	End Date (YYYY / MM / DD)

Facility Name	Facility Number
Facility Name	Facility Number
Facility Name	Facility Number
Facility Name	Facility Number
Facility Name	Facility Number
Facility Name	Facility Number

LABORATORY PHYSICIAN STAFF

Complete this part if there will be a change in the laboratory medicine physicians providing or supervising the provision of benefits through the laboratory facility, previously identified in an application or notification of change.

If the below listed laboratory physicians wish to bill the BC Medical Service Plan for outpatient services, an Operator Payment Administration (OPA) form must be completed and submitted for processing.

The OPA form and User Guide can be found on the Laboratory Services website at:
https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/laboratory-services-diagnostic-services/laboratory-services/forms

PREVIOUS PHYSICIAN INFORMATION	NEW PHYSICIAN INFORMATION
Name	Name
Specialty	Specialty
MSP Practitioner Number	MSP Practitioner Number

PREVIOUS PHYSICIAN INFORMATION	NEW PHYSICIAN INFORMATION
Name	Name
Specialty	Specialty
MSP Practitioner Number	MSP Practitioner Number

LABORATORY PHYSICIAN STAFF continued

PREVIOUS PHYSICIAN INFORMATION	NEW PHYSICIAN INFORMATION
Name	Name
Specialty	Specialty
MSP Practitioner Number	MSP Practitioner Number

PREVIOUS PHYSICIAN INFORMATION	NEW PHYSICIAN INFORMATION
Name	Name
Specialty	Specialty
MSP Practitioner Number	MSP Practitioner Number

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PART B - OPERATOR OR PERSON IN CHARGE OF OPERATIONS

Complete this part if there will be a change to the current operator. Provide the name of the preceding and succeeding operator.

According to the *Laboratory Services Act,* an Operator, in relation to a facility, means:

- the owner;
- the person having responsibility for the daily operations of the laboratory facility; or
- a regional health board or prescribed agency.

PRECEDING OPERATOR INFORMATION	SUCCEEDING OPERATOR INFORMATION
Name	Name
Title	Title
Email	Email
Phone Number	Phone Number

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PART C - HOURS OF OPERATION

Complete this part if the hours of operation at a laboratory or specimen collection facility will change.

Note: If changing the hours of operation will affect the total volume of throughput and testing to greater than 20% over the previous 12-month period, the organization must apply for an amendment to their Approval for significant change to capability or capacity.

LABORATORY HOURS OF OPERATION							
Current hours of operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
New hours of operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
SPECIMEN COLLECTION STATION HOURS OF OPERATION							
Current hours of operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
New hours of operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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PART D - BEDS/STRETCHERS, PHLEBOTOMY CHAIRS, AND EQUIPMENT

Complete this part if the facility intends to add or remove a bed/stretcher, phlebotomy chair, or piece of equipment.

BEDS/STRETCHERS, PHLEBOTOMY CHAIRS

	Beds/Stretchers	Phlebotomy Chairs
Current Number		
Current Maximum Number		
New Number		

Complete this part if the major equipment used at the laboratory facility will change and result in a change in capability and capacity output.
Provide details of the actual capability and capacity of the equipment.

Note: If the addition or removal of beds/stretchers, phlebotomy chairs, or equipment changes the volume of patient throughput to greater than 20% over the previous 12-month period, the organization must apply for an amendment to their Approval for significant change to the capability or capacity.

EQUIPMENT

Name/Brand of Equipment	New Equipment	Year/Make/Model	Capability (Max Output/day)	Capacity (Max Output/day)
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

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PART E - WITHDRAWAL OF OUTPATIENT FEE-FOR-SERVICE(S)

Please complete this part if accreditation by the College of Physicians and Surgeons of British Columbia's Diagnostic Accreditation Program has changed or the facility will no longer provide a specific outpatient fee-for-service item or category of items.

Visit the Laboratory Services website for a list of Fee-for-Service Outpatient Laboratory Facility Approval Categories and fee items:
https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/laboratory-services/facility_approval_categories_oct_1_2015.pdf

OUTPATIENT FEE-FOR-SERVICE CATEGORIES (please indicate all that apply)

- ☐ Specimen Collection Services
- ☐ Category 1 - General Laboratory Tests
- ☐ Category 2A – Hematology
- ☐ Category 2B – Microbiology
- ☐ Category 2C - Clinical Chemistry
- ☐ Category 2M – Category 3 minus all Microbiology fee items
- ☐ Category 3 – Full Approval (minus the Specialty Categories)

OUTPATIENT FEE-FOR-SERVICE SPECIALTY CATEGORIES

- ☐ Category 2G – Cytogenetics
- ☐ Category 2V – Virology
- ☐ Category 2S – Specialized

OUTPATIENT FEE ITEMS/TEST MENUS

Fee Item Number	Fee Item Description

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PART F - FACILITY CLOSURE – TEMPORARY OR PERMANENT

Complete this part if a laboratory or specimen collection facility will be closing either temporarily or permanently due to staffing, instrumentation, accreditation, or other such issues.

Facility Name	Facility Number

Facility Address

Type of Closure	Effective Date of Closure (YYYY/ MM / DD)	End Date, if applicable (YYYY / MM / DD)
☐ Temporary ☐ Permanent		

Reason for Closure

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PART G - PAYMENT NUMBER ADDITION OR CANCELLATION

Complete this part to add, cancel, or change a payment number associated with a facility number.

Note: Payment numbers are issued by Health Insurance BC (HIBC). Contact HIBC by visiting their website at:
http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-insurance-bc

Facility Name		Facility Number
Mailing Address		
Current Payee Number	Current Payee Name	End Date, if applicable (YYYY / MM / DD)
New Payee Number	New Payee Name	Start Date (YYYY / MM / DD)
New Payee Number	New Payee Name	Start Date (YYYY / MM / DD)

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PART H - RECEIVING/TESTING LABORATORY

Complete this part if there will be a change, or addition, to a specimen collection station's associated receiving and testing laboratory(ies).

Note: All specimen collection stations are associated with a laboratory that provides testing and interpretation.

Indicate if there is an addition or change to the receiving laboratory

☐ **Adding a Receiving Laboratory** ☐ **Changing the Receiving Laboratory**

SPECIMEN COLLECTION STATION INFORMATION	
Name	Facility Number

CURRENT RECEIVING LABORATORY INFORMATION	
Name	Facility Number
Address	

NEW RECEIVING LABORATORY INFORMATION	
Name	Facility Number
Address	

NEW RECEIVING LABORATORY INFORMATION	
Name	Facility Number
Address	

NEW RECEIVING LABORATORY INFORMATION	
Name	Facility Number
Address	

NEW RECEIVING LABORATORY INFORMATION	
Name	Facility Number
Address	

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PART I - SHAREHOLDERS

Complete this part if the ownership status of an organization will change. Include all partners to ensure 100% of ownership is reflected.

Note: The organization must apply for a Change to an Existing Approval if a person/shareholder has a material financial interest of more than 10% of shares in the business.

Foreign Ownership? ☐ Yes ☐ No	
Partnership/Corporation Name	
Partnership/Corporation Address	
Operator Name (registered legal name)	
Operator Mailing Address	
Name of Shareholder	Percentage Owned
Business Address	
Name of Shareholder	Percentage Owned
Business Address	
Name of Shareholder	Percentage Owned
Business Address	

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PART J(A) - CONFLICT OF INTEREST DECLARATION AND DISCLOSURE

Sections 7(2)(f) and 8(1)(c) of the Laboratory Services Regulation, found at: http://www.bclaws.ca/civix/document/id/complete/statreg/52_2015 requires that an application for approval of a laboratory facility **must include** information about any existing, or potential conflicts of interest the applicant has reason to be aware of in respect to referring practitioners who may request benefits to be provided through the laboratory facility.

For the relevant policy, see Policy 2.5.3 of the Approval-Related Policies and Guidelines for Laboratory Facilities Providing Outpatient Laboratory Services on a Fee-For-Service Basis and the Laboratory Facilities Conflict of Interest Policy, found at:
http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/laboratory-services/facilities_approvals_policy.pdf

FACILITY OPERATOR DECLARATION

ATTENTION: The person completing/signing this Disclosure Form (the "authorized signatory") must be duly authorized to make the declaration/disclosure on behalf of the operator/owner required to make the declaration/disclosure. Part K must be completed and signed by the applicant to ensure processing of application.

Is there an existing or potential conflict of interest to disclose in relation to the laboratory facility? **Check one:**

☐ **Yes**, there is an existing or potential conflict of interest to disclose in relation to the laboratory facility.
If yes, provide details of the existing or potential conflict of interest in Part J(B).

☐ **No,** there is no existing or potential conflict of interest to disclose in relation to the laboratory facility.
If no existing or potential conflict of interest is indicated, sign and complete signatory declaration at the end of this form.

☐ **I am unsure** if the circumstances constitute, or may constitute, an existing or potential conflict of interest.
If unsure, provide details of the potential conflict of interest in Part J(B).

PART J(B) - CONFLICT OF INTEREST DECLARATION AND DISCLOSURE

Laboratory Facility Name

Full names of all relevant practitioners, family members, laboratory facility owners (including the declarant), or business associates, who hold, or may hold, a relevant financial or material interest

Any relevant affiliations or relationships with the owner, or intended owner of the laboratory facility, and the details of any interest or benefit that may relate to a conflict of interest

Any other information, including dates, that is relevant to understanding and assessing the nature, scope and degree/extent of an existing, or potential, conflict of interest

Additional Information (if required) that is relevant to understanding and assessing the nature, scope and degree/extent of an existing or potential conflict of interest. Include any details regarding proposed avoidance or mitigation measures related to any existing or potential conflicts of interest (append listing if required)

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PART K - APPLICATION AUTHORIZATION

Attention Authorized Representative (signatory): The person completing/signing this application form (the "authorized signatory") must be duly authorized to make the application on behalf of the operator/owner.

Name	
Title	
Signature	Date (YYYY / MM / DD)

Submit this completed form with enclosures through the Ministry of Health's secure upload tool, located at:
http://www.gov.bc.ca/labservicesupload

PRINT

CLEAR FORM