

REQUEST FOR COMPLAINT INVESTIGATION OR VALIDATION SURVEY OF ACCREDITED LABORATORY

1. NAME AND ADDRESS OF STATE AGENCY	2A. NAME AND ADDRESS OF LABORATORY
	2B. CLIA NUMBER

3. LABORATORY ACCREDITATION BY _____

4. THIS VALIDATION IS BASED ON A SAMPLE SELECTION. PLEASE CONDUCT A FULL SURVEY OF APPLICABLE ACCREDITED SPECIALTIES AND SUBSPECIALTIES WITHIN 90 DAYS. NOTIFY THIS OFFICE IF THE SURVEY WILL BE PERFORMED SIMULTANEOUSLY WITH THE ACCREDITATION ORGANIZATION'S ONSITE INSPECTION.
5. THIS COMPLAINT INVESTIGATION/VALIDATION IS BASED ON A SUBSTANTIAL ALLEGATION OF NONCOMPLIANCE. PLEASE INVESTIGATE THE AREAS CHECKED BELOW.

6. AREAS TO BE SURVEYED *(Check all applicable Conditions; enter all applicable Standards or Specialties/Subspecialties)*

CONDITION(S)/PROPER CERTIFICATE	STANDARDS OR SPECIALTIES/SUBSPECIALTIES
<input type="checkbox"/> Proficiency Testing	_____
<input type="checkbox"/> Patient Test Management	_____
<input type="checkbox"/> Quality Control	_____
<input type="checkbox"/> Personnel	_____
<input type="checkbox"/> Quality Assurance	_____
<input type="checkbox"/> Operating Without Certificate of Accreditation	_____
<input type="checkbox"/> Other _____	_____

7. REMARKS _____

8. REGIONAL REPRESENTATIVE	9. REGION	10. DATE
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