



Application Form – Moratorium Exemption Request – New Facility

(Submit request through the secure upload tool: <https://labfacilities.phsa.ca/secureupload>)

Section 1 Application Information

Date Info	Application Date	Proposed Start Date	
Facility Type	Specimen Collection	Testing Laboratory	Combined
Requestor contact information	Name	Title/Position	
	Email	Phone No.	

Section 2 Facility Information

Facility Information	Legal Name
	Address
	Organization
Medical Director	Name
	Credentials
	MSP Practitioner #
	Email
	Phone

Section 3 Facility Ownership Information

Ownership	Public (go to section 3.1)	Private (go to section 3.2)	
3.1 Public	Health Authority		
	Health Authority Address		
3.2 Private	Foreign Ownership	Yes	No
		Sole Proprietor (complete section 3.2a)	
		Partnership (complete section 3.2b)	
		Corporation (complete section 3.2c)	
		Other – Specify:	



3.2a Sole Proprietor	Name		
	Address		
3.2b Partnership	Partnership Name		
	Partnership Address		
	Legal Registered Operator Name		
	Operator Mailing Address		
	Partner Information (attach separate document if required)		
	Name of Partner	Business Address	% Owned
Total Percentage (must equal 100)			
3.2c Corporation	Corporation Name		
	Corporation Address		
	Corporation Number		
	Date of Incorporation		
	Officer/Director Information (attach separate document if required)		
	Name	Title/Position	Business Address
Shareholder Information (attach separate document if required)			
Name of Partner	Business Address	% Owned	
Total Percentage (must equal 100)			



Section 4 Sample Collection Services

Sample Collection Services	Funding Type	Global						Fee-for-Service
	Square Feet							
	Number of Patient Washrooms							
	Number of Staff Washrooms							
	Amount of Free Parking							
	Amount of Paid Parking							
	Proposed number of chairs							
	Proposed number of beds							
	Proposed number of staff							
	Provide details on where staff will be recruited from including any contracted staff							
	Walk-in Service Available?							
	Appointments Available?							
	Wait Times Published?							
	ECGs Performed?							
	Holter Monitoring?							
	Ambulatory BP Monitoring?							
	Anticipated Monthly Patient Throughput							
	Proposed Days and Hours of Operation							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Stats
	Associated Testing Facility (if not included below in this application)							
Facility ID Number								
Facility Name								
Facility Address								
Qualified laboratory medicine physician for the facility		Name						
		Credentials						



Section 5 Testing Services

Testing Services	Funding Type	Global	Fee-for-Service	Combined			
	Fee-for Service Categories (check all applicable boxes)			Anticipated Monthly Volume			
	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 excluding categories 2G, 2V, 2S						
	Category 2G – Cytogenetics						
	Category 2V – Virology						
Category 2S – Specialized							
Individual Fee Item Numbers and Test Names			Anticipated Monthly Volume				
<p>Square Feet</p> <p>Proposed number of staff</p> <p>Provide details on where staff will be recruited from including any contracted staff</p>							
Proposed Days and Hours of Operation							
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Stats
Laboratory Medicine Physicians (attach separate document if required)							
Name		Laboratory Medicine Credential		MSP Number			



Section 6 Accreditation Information

Diagnostic Accreditation Program (DAP) Status	Accredited	Effective Date	Expiry Date
	DAP Facility Code (if assigned)		
	Check all Accredited Scopes of Service		
	Sample Collection		
	Anatomical Pathology		
	Chemistry		
	Hematology		
	Microbiology		
	Molecular Diagnostics		
	Point of Care Testing		
	Transfusion Medicine		
	Accreditation Pending	Provisional Accreditation Date	
	Check all Scopes of Service to be Accredited		
	Sample Collection		
	Anatomical Pathology		
	Chemistry		
	Hematology		
	Microbiology		
	Molecular Diagnostics		
	Point of Care Testing		
	Transfusion Medicine		
	Accreditation Withdrawn/Denied (provide details)		



Section 7 Exemption Criteria

<p>Applicable Exemption Criteria <i>Complete all that apply</i></p>	<p>Urgent Health Need Explain in detail</p> <p>Safety need Explain in detail</p> <p>Business need Explain in detail</p>
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Section 8 Additional Information

Additional information	Provide details of any First Nations or Indigenous populations in the proposed service area
	Provide details of any vulnerable and/or marginalized populations in the proposed service area
	Provide details of any other laboratory service providers who have been consulted regarding any of the proposed services
	Provide any other information relevant to this application
<i>Attach any other supporting documents relevant to this application</i>	