Accreditation Program Application Request Form

For laboratories/facilities seeking accreditation for multiple accreditation programs and/or laboratory sites, Clinical Laboratory Improvement Amendments (CLIA) numbers, satellite, clinic, or special-function laboratories, please reproduce this form and submit a separate ***Application Request Form*** and fee for each laboratory/facility or each accreditation program.

Please make your program selection (required)

- [x] Laboratory Accreditation Program (General - LAP)
- [ ] Reproductive Laboratory Accreditation Program (RLAP)
- [ ] Forensic Drug Testing Accreditation Program (FDT)
- [ ] Biorepository Accreditation Program (BAP)

CAP Number

CAP Number (if available)

CLIA Number

CLIA Number (if available)

D

Who currently accredits or certifies your laboratory?

What is the accredition end date

Month / Day / Year

Laboratories interested in the CAP15189 Accreditation Program must complete LAP accreditation first. For information about preparing for CAP15189 Program contact CAP15189@cap.org.

Patient Testing

Has patient testing started

- [ ] Yes
- [x] No

If **"No"** provide anticipated start date

10 / 01 / 2024

Month / Day / Year

Domestic*

Is the laboratory requesting this application enrolled in CAP Proficiency Testing Program(s)?

- [ ] Yes
- [x] No
- [ ] N/A (for BAP only)

International not subject to US (CLIA) regulations**

Has your laboratory been enrolled in CAP Proficiency Testing Program for at least 6 months? (Do not continue with this request if **"No"** was answered. Contact the CAP for assistance.)

- [ ] Yes
- [ ] No

** Includes US, Canada, Puerto Rico, and Guam*

*** Does **not** include Canada, Puerto Rico, and Guam*

Laboratory/Facility Information (required)

Hospital or Institution Name

Hidalgo County

Laboratory/Facility Name

Public Health Laboratory

Physical Address/Street Address

1211 S 28th Ave

City

Edinburg

State

TX

Postal Code

78542

Province (Use abbreviation)

Country

USA

Phone

Country Code | Area Code | Laboratory/Facility Phone | Extension | Area Code | Laboratory/Facility Fax

9562927765

Laboratory /Facility Contacts (required)

Laboratory/Facility Director

First Name

Martha

Last Name

Luna

- [x] MD
- [ ] DO
- [ ] PhD
- [ ] Other

Laboratory Director E-mail Address

martha.luna@hchd.org

Primary Contact Person (required)

First Name

Veronica

Last Name

Cuate

Contact E-mail Address

veronica.cuate@hchd.org

40310

Shipping Address (required for Accreditation related packages)

○ Same as physicial ○ Same as Billing address
◉ Same as Mailing address

Shipping Address

1304 S 25th Ave

City: Edinburg | State: TX | Postal Code: 78542

Province (Use abbreviation): | Country: USA

Mailing Address (required for Accreditation related envelopes)

○ Same as physicial ○ Same as Billing address
◉ Same as Shipping address

Mailing Address

City: | State: | Postal Code:

Province (Use abbreviation): | Country:

Billing Contact and Address

Billing Contact (required)

First Name: Miguel | Last Name: Escaname

E-mail Address (required): mike.escaname@hchd.org

Address: 1304 S 25th Ave

City: Edinburg | State: TX | Postal Code: 78542

Province (Use abbreviation): | Country: USA

54171

Payment Information

A nonrefundable application fee of $1250 (domestic) and $1550 (international**) is required per laboratory/facility to initiate the application process. The application fee may be waived if CAP accreditation checklists have been purchased within the past six months.*

If you are applying for multiple accreditation programs and/or multiple CLIA numbers, satellites, clinics, or special-functions laboratories, please submit a separate Application Request Form and fee for each program or site being accredited.

Total Payment $ 1250.00

Payment Options (choose one):

◉ Check

Check Number

○ Credit Card **To pay with a credit card using this form, please contact the CAP directly at 800-323-4040 ext. 1. Or for international customers, 847-832-7000, ext 1.**

○ Wire Transfer Include Institution Name and state; "Accreditation Application fee" when remitting payment. Please include all bank fees with your payment. Notify the CAP at arcap@cap.org upon completion of the transfer.

Remit wire transfer payment to:
BMO Harris Bank
111 West Monroe Street
Chicago, IL 60606, USA
Phone: 312-461-2121

ABA Number: 071000288
Account Number: 2237337
SWIFT#:HATRUS44

○ Accreditation Checklist has been purchased

Order # _____

Submit this Form by one of these methods:

If payment method is credit card or wire transfer, email form to Customer Data Management (CDM) at:

Email: cdm@cap.org

If you are submitting your payment by check please mail the form and check to:

College of American Pathologists
325 Waukegan Road
Northfield, IL 60093-2750

For more information, please call the CAP at 1-800-323-4040, option 1 (domestic), or 847-832-7000 (Country code 001), option 1 for international.

COLLEGE of AMERICAN PATHOLOGISTS