

**APPLICATION FOR LICENSE TO OPERATE A  
DRUG AND/OR ALCOHOL TESTING FACILITY**

*INSTRUCTIONS*

- I. Read carefully and complete all portions of the application. Please type or print.
- II. Application for license may be made by the owner, director, or other individuals who have responsibility for maintaining approved standards for the institution.
- III. A separate application shall be completed for:
  - (a) Each testing facility location (a facility that moves from testing site to testing site shall indicate the address of its primary site);
  - (b) Each van or other mobile unit providing laboratory services.
- IV. License fee must accompany the application. Checks, money orders or bank drafts must be made payable to OKLAHOMA STATE DEPARTMENT OF HEALTH. No such fee shall be refunded. The license fee for each testing facility shall be one hundred fifty dollars (\$150.00) annually.

**Class of License** (check **all** applicable classes performed):

- |                                                    |                                                       |
|----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Initial Drug Screening    | <input type="checkbox"/> Confirmatory Drug Testing    |
| <input type="checkbox"/> Initial Alcohol Screening | <input type="checkbox"/> Confirmatory Alcohol Testing |

- V. **Any changes are to be reported promptly to the address above.**

The undersigned hereby makes application for license to operate a drug and/or alcohol testing facility subject to the provisions of the Oklahoma Statutes and to the regulations adopted thereunder by the State Board of Health for:

**1. OPERATING ENTITY:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

\_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

(Name)

Fax Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

D.B.A. (If facility operates under another name): \_\_\_\_\_

**2. Finding Address** \_\_\_\_\_

(Number & Street)

\_\_\_\_\_  
(City) (County) (State) (Zip)

**3. Mailing Address** \_\_\_\_\_

(Number) (Street) (City) (County) (State) (Zip)

**4. Name of Director** \_\_\_\_\_

FOR DEPARTMENT USE ONLY

Receipt #: \_\_\_\_\_ License #: \_\_\_\_\_ Issued: \_\_\_\_\_

Amount \$ \_\_\_\_\_ License Type: \_\_\_\_\_ Expires: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Screening laboratories must provide the following:** Attach as an enclosure and number the response (5).

- (a) Names and qualifications of all technical staff in accordance with 310:638-5-2;
- (b) Proof of enrollment and satisfactory performance in an approved proficiency testing program; and
- (c) Name and address of the testing facility(ies) utilized for confirmation testing.

**6. Facilities seeking licensure based on certification by the United States Department of Health and Human Services or accreditation by the College of American Pathologists must submit proof of current certification or accreditation.**

Attach such proof as an enclosure and number the response (6).

**7. SIGNATURE OF APPLICANT(S)**

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Typed Name: \_\_\_\_\_ Typed Name: \_\_\_\_\_

Title or Position: \_\_\_\_\_ Title or Position: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**9. AFFIDAVIT**

STATE OF \_\_\_\_\_

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, personally appeared before me

\_\_\_\_\_ and \_\_\_\_\_

whose identity is personally known to me (or proved to me on the basis of satisfactory evidence) and who by me duly sworn (or affirmed), did say that to the best of his/her knowledge and belief, the statements in the foregoing application are true and correct and the he/she acknowledged the he/she executed it.

Subscribed and sworn to before me \_\_\_\_\_  
(Notary Public)

My commission expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

**QUESTIONNAIRE**

Mark the box for each drug/metabolite tested in your laboratory and indicate the methodology used for screening and/or confirmatory testing. Please return the completed questionnaire along with your drug and alcohol testing application.

**FACILITY NAME:**

<b>DRUG/METABOLITE</b>	<b>SCREENING METHOD</b>	<b>CONFIRMATORY METHOD</b>
<input type="checkbox"/> Alcohol		
<input type="checkbox"/> Marijuana		
<input type="checkbox"/> Cocaine		
<input type="checkbox"/> Codeine		
<input type="checkbox"/> Hydrocodone		
<input type="checkbox"/> Hydromorphone		
<input type="checkbox"/> Meperidine		
<input type="checkbox"/> Methadone		
<input type="checkbox"/> Oxycodone		
<input type="checkbox"/> Propoxyphene		
<input type="checkbox"/> Herion		
<input type="checkbox"/> Morphine		
<input type="checkbox"/> Phencyclidine		
<input type="checkbox"/> Amphetamines		
<input type="checkbox"/> Methamphetamines		
<input type="checkbox"/> Methylenedioxyamphetamine		
<input type="checkbox"/> Methylenedioxymethamphetamine		
<input type="checkbox"/> Phentermine		
<input type="checkbox"/> Amobarbital		
<input type="checkbox"/> Butalbital		
<input type="checkbox"/> Pentobarbital		
<input type="checkbox"/> Secobarbital		
<input type="checkbox"/> Diazepam		
<input type="checkbox"/> Chlordiazepoxide		
<input type="checkbox"/> Alprazolam		
<input type="checkbox"/> Clorazepate		
<input type="checkbox"/> Methaqualone		

**Please indicate any other drugs/metabolites for which you do testing:** \_\_\_\_\_  
 \_\_\_\_\_

**Hours of Operation:** Please indicate the hours testing will be performed at the address listed on your application.

	<b>Sunday</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>
<b>From (AM) :</b>							
<b>To (PM) :</b>							

Mobile facilities should include a schedule of testing locations. If a schedule is not available or unknown at the present time, please include a telephone number, email address, or other information we may use to contact the facility to arrange for inspection.