Government of Saskatchewan

Laboratory Licensing
Saskatchewan Disease Control Laboratory
5 Research Drive
Regina, Saskatchewan S4S 0A4
Phone: (306) 787-3130
Fax: (306) 787-1525
Email: LabLicensing@health.gov.sk.ca

APPLICATION/RENEWAL FOR A LICENCE TO OPERATE A MEDICAL LABORATORY

All sections of the application form are required to be completed prior to submission to the Ministry

New Application ❑ Date of Application/Renewal: _____/_____/_____

Renewal ❑ Licence # _____ MM DD YEAR

Laboratory Facility

Name of Facility_____ Telephone # _____

Street Address _____ Fax # _____

City _____Postal Code _____ Email _____

Mailing Address (if different than above) _____

City _____ Postal Code _____

Regional Health Authority physically located in: _____

Type of Licensee

Individual ❑ Corporation ❑ Partnership ❑

Regional Health Authority ❑ Provincial Government ❑ Canadian Blood Services ❑

Hospital ❑ Other (please specify) Outreach testing

Licensee Information

Name _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____Postal Code _____ Email _____

If partnership or corporation - partners or directors:

Name n/a Title or Position _____

Mailing Address _____ Telephone # _____

City _____Postal Code _____ Email _____

Name _____ Title or Position _____

Mailing Address _____ Telephone # _____

City _____Postal Code _____ Email _____

Name _____ Title or Position _____

Mailing Address_____ Telephone # _____

City _____Postal Code _____ Email _____

Ownership of Facility Premises

Does the Licensee own the premises? Yes ❑ No ☒

If Licensee **does not** own the laboratory premises:

Lease expiry date: _____/_____/_____
MM DD YEAR

Premises Owner's:

Name _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____ Postal Code _____ Email _____

Qualified Professional: (See Appendix A)

Name Leegay Jagoe

Professional Qualification RN, BSN, MN Telephone # (306) 216-7687

Mailing Address Health Canada, FNIHB, 4th Floor, 2045 Broad Street Fax # (306) 780-5107

City Regina Postal Code S4P 3T7 Email leegay.jagoe@hc-sc.gc.ca

Main Laboratory Contact:

Name as above Telephone # _____

Mailing Address _____ Fax # _____

City _____ Postal Code _____ Email _____

Signatures:

I/We, in applying for a licence to operate a medical laboratory, state that the information and data contained herein is correct.

I/We hereby authorize the Ministry of Health and the Accreditation Program to share, one with the other, any information possessed by the Ministry or the Program in relation to my/our provision of medical services in the past and future.

Signature	Name & Title (please print)	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Updated January 2013

IMPORTANT:

1. Complete the attached List of Tests.
2. Complete the attached List of Staff.

Licence # _____

List of Tests

Name of Test
HIV Screen
Hepatitis B surface antigen
Hepatitis B surface antibody
Syphilis
Rapid POCT HIV
Hepatitis C antibody
Hepatitis A IgG (immune)
Hepatitis A IgM
Chlamydia & Gonorrhea Screen urine

Updated January 2013

Licence # _____

List of Staff

Last Name	First Name	Employment Start (MM/DD/YEAR)	Position Location in laboratory/clinic	Designation Professional Qualification	Cert. Year Professional Qualification Year	Educational Upgrades
Jagoe	Leegay	2013	outreach	RN	1994	MN

Updated January 2013