NL Health Services

Application for External Collector Permit (Part I)

Prior to completing the application, please read the *Agreement for Specimen Collection by External Agencies*.
Ensure application parts A and B are fully and legibly completed email to Collector.Applications@nlhealthservices.ca

A. SPECIMEN COLLECTOR INFORMATION			
Was a permit number previously issued to applicant? ☐ Yes ☐ No		**If yes provide number:**	
Name of Organization	*<Business name or individual operating under own name >*	**Company Registry Number**	*<If not applicable – enter N/A>*
Business Owner(s)			
Signing Authority	☐ As above (business owner) ☐ Other (name) _____		
Mailing address			
Telephone number		**Cell number**	
Email address			
Centrifugation	We will be performing centrifugation of specimens? ☐ Yes ☐ No		
Specimen transport	We will use NL Health Services Eastern Zone validated containers and packing scheme? ☐ Yes ☐ No		
	We will be validating our own transport containers for use? ☐ Yes ☐ No		

Please submit proof of the following documentation:

☐ Certificate of general liability and/or professional liability insurance.
☐ Signed and notarized Oath Affirmation of Confidentiality Contractors Suppliers for each owner and specimen collectors
☐ Centrifuge information form #20353 for each centrifuge (if conducting centrifugation)
☐ Centrifuge initial qualification record for each centrifuge (if conducting centrifugation)
☐ Specimen transport container validation documentation (If *not* using NLHS Eastern Zone container/packing scheme)

APPLICATION SUBMITTED BY	
Name (print):	Title:
Signature:	Date: DD/MM/YYYY

NL Health Services

Laboratory Medicine

Application for External Collector Permit (Part II)

COMPLETE SECION B FOR EACH SPECIMEN COLLECTION FACILITY

B. SPECIMEN COLLECTOR LOCATION/STAFFING			
Location (name)	*<If different than organization name in section A >*		
Complete address			
Location contact	☐ Business owner (as provided in section A of application)		
	☐ Other: complete the following: **Name:**		
	Telephone number:	**Cell number**	
	Email *<Monitored email mandatory>*		
Days of collection	*<Indicate days of collection (no expansion to that defined in Collectors Agreement)>*		
Hours of collection	*<Indicate hours of collection (no expansion to that defined in Collectors Agreement)>*		
Mobile collection *e.g., at patient residence*	☐ Mobile only	☐ On-site collections only	☐ Both on-site and mobile
Drop off location *Select all that apply*	**St. John's:** ☐ Health Sciences Centre	**Rural Avalon** ☐ Carbonear ☐ Bell Island ☐ Old Perlican ☐ Placentia ☐ Whitbourne	**Peninsulas** ☐ Clarenville ☐ Bonavista ☐ Burin ☐ Grand Bank ☐ St. Lawrence

LIST OF PHLEBOTOMISTS

Name	**Individual professional liability insurance held?**	**Signature**
	☐ **Yes** ☐ **No**	
	☐ **Yes** ☐ **No**	
	☐ **Yes** ☐ **No**	
	☐ **Yes** ☐ **No**	
	☐ **Yes** ☐ **No**	
	☐ **Yes** ☐ **No**	
	☐ **Yes** ☐ **No**	

COURIERS/INDIVIDUALS WHO WILL TRANSPORT SPECIMENS

Name	**Transportation of dangerous goods certified?**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**

INSERT OR ATTACH ADDITIONAL TABLES, AS NECESSARY.