Laboratory Licensing
Medical Services Branch
2nd floor - 3475 Albert Street
Regina, Saskatchewan S4S 6X6
Phone: (306) 787-7988
Fax: (306) 798-1124
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 _____

Type of Licensee

Individual ☐ Corporation ☐ Partnership ☐

Health Authority ☐ Provincial Government ☐ Canadian Blood Services ☐

Hospital ☐ Other (please specify) _____

Licensee Information

Name _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____Postal Code _____ Email _____

If partnership or corporation - partners or directors:

Name _____ 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 _____

Professional Qualification _____ Telephone # _____

Mailing Address _____ Fax # _____

City _____ Postal Code _____ Email _____

Main Laboratory Contact:

Name _____ 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 April 2018

IMPORTANT:

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

Licence # _____

List of Tests

Name of Test

Updated April 2018

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