



DEPARTMENTS OF THE ARMY AND THE AIR FORCE

NATIONAL GUARD BUREAU
2500 ARMY PENTAGON
WASHINGTON, D.C. 20310-2500



NGB-ARS

18 DEC 1997

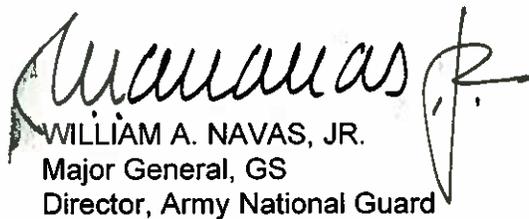
MEMORANDUM FOR THE ADJUTANTS GENERAL OF ALL STATES, PUERTO RICO,
THE VIRGIN ISLANDS, GUAM, AND THE DISTRICT OF
COLUMBIA

SUBJECT: All States (Log Number I98- 0058) Department of Defense Clinical Laboratory
Improvement Program

1. The State Area Command (STARC) Medical Detachment laboratories are subject to the provisions of the Department of Defense Clinical Laboratory Improvement Program (DOD CLIP) as contained in Armed Forces Institute of Pathology Pamphlet (AFIP Pam) 40-24, dated 8 July 1996. Previous editions are not applicable. Army National Guard medical activities must adhere to the provisions of DOD CLIP to remain in compliance with the Clinical Laboratories Improvement Amendments Act of 1988.
2. In accordance with AFIP Pam 40-24, chapter 2 the STARC Medical Detachments qualify for certification as laboratories performing minimally complex tests. The tests authorized by DOD CLIP are outlined in paragraph 2-3c., 1-14. Following the procedures outlined in Chapter 3, AFIP Pam 40-24 will complete the certification process and allow the STARC Medical Detachments to perform these tests.
3. Because of the requirements for specialized personnel, equipment and quality control the STARC Medical Detachments will not qualify for certification as a moderate or highly complex laboratory.
4. Enclosed is a copy of AFIP Pam 40-24, Appendix C, Key to Registration and a DOD CLIP Registration Form to assist with certification.
5. The point of contact is MSG Lansing, at commercial 703-607-7145 or DSN 327-7145.

FOR THE CHIEF, NATIONAL GUARD BUREAU:

Encl
as


WILLIAM A. NAVAS, JR.
Major General, GS
Director, Army National Guard

DISTRIBUTION:
1 Each STARC Med Det
NGB-IG
Each State IG



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Small handwritten text on the right side.

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APPENDIX C

KEY to REGISTRATION CERTIFICATES

Certificate for Minimally Complex Testing

Testing limited to: Non-automated urinalysis (dipstick/tablet reagent); fecal/gastric occult blood; visual color ovulation and urine pregnancy tests; blood glucose by devices cleared by the FDA for home use; non-automated ESR; non-automated hemoglobin; spun hematocrit; hemoglobin by single analyte instruments; Group A Strep tests; *H. pylori* tests; rapid cholesterol tests.

Personnel Requirements: No defined educational level requirement
Proficiency testing: None required
Inspections: As required
Reference: Chapters 2 & 3, TM 8-XXX/NAVMED P-XXXX/AFI 41-XXX

Certificate for Provider-Performed Microscopy

Testing limited to: Wet mounts; KOH preps, fern tests; post-coital direct exams of vaginal/cervical mucous; pinworm exams; urine sediment; nasal smear for granulocytes; fecal leukocyte exams; qualitative semen analysis.

Personnel Requirements: Must be performed by physician, Nurse Practitioner, Nurse Midwife, PA or Dentist at time of patient visit
Proficiency testing: Required where available
inspections: As required
Reference: Chapters 2 & 4, TM 8-XXX/NAVMED P-XXXX/AFI 41-XXX

Certificate for Moderate Complexity Testing

Testing includes: Waived tests; provider performed microscopy, plus: automated chemistry; basic bacteriology; automated hematology; non-transfusion related immunohematology.

Personnel Requirements: Must satisfy requirements for: Director, Clinical Consultant, Technical Consultant and Testing personnel

Proficiency Testing: All named analytes

Inspections: Every 2 years

Reference: Chapters 2 & 5, TM 8-XXX/NAVMED P-XXXX/AFI 41-XXX

Certificate for High Complexity Testing

Testing Includes: All in moderately complex, plus: Parasitology; transfusion related immunohematology; manual procedures; microbiology; histopathology; cytology

Personnel Requirements: Must satisfy requirements for: Director, Clinical Consultant, Technical Supervisor, General Supervisor and Testing personnel

Proficiency Testing: All named analytes

Inspections: Every 2 years

Reference: Chapters 2 & 5, TM 8-XXX/NAVMED P-XXXX/AFI 41-XX

**DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, D.C. 20306-6000**

THE DoD CLINICAL LABORATORY IMPROVEMENT PROGRAM (CLIP)

REGISTRATION FORM FOR WAIVED TESTING

Type or print legibly the following information. Reproduction of this form is authorized.

I. General Information

FACILITY NAME			Armed Forces Institute of Pathology Office of Clinical Laboratory Affairs ATTN: AFIP-ZD 8403 Colesville Rd, Bldg 2, Suite 860 Silver Spring, MD 20910-3368		
ADDRESS					
			DoD-CLIA Number (For office use only)		
CITY	STATE	ZIP+4	Laboratory Affiliation (Circle one only)		
TELEPHONE ()	DSN		01 Army	05 Navy Reserve	09 Army Reserve
Defense Medical Information System Identification Code (DMISID)			02 Navy	06 Air Nat'l Guard	11 DoD
			03 Air Force	07 Air Force Reserve	12 MEPS
			04 USMC	08 Army Nat'l Guard	13 Other _____

Type of Certificate (check one only)

See Appendix A for information

- Certificate for Waived Testing (Single Site Only)
- Certificate for Waived Testing (Multiple Sites)

III. Type of Laboratory

- | | | |
|---|--|---|
| <input type="checkbox"/> 01 Ambulatory Surgery Center | <input type="checkbox"/> 06 Satellite Laboratory | <input type="checkbox"/> 11 Troop Medical Clinic |
| <input type="checkbox"/> 02 Outpatient Clinic | <input type="checkbox"/> 07 Industrial | <input type="checkbox"/> 12 Emergency Services |
| <input type="checkbox"/> 03 Bedside Testing Site (i.e. Wards) | <input type="checkbox"/> 08 Mobile Unit | <input type="checkbox"/> 13 Physical Examinations |
| <input type="checkbox"/> 04 Renal Dialysis Facility | <input type="checkbox"/> 09 Pharmacy | <input type="checkbox"/> 14 Other (specify) _____ |
| <input type="checkbox"/> 05 X-ray | <input type="checkbox"/> 10 Pulmonary Function | _____ |

IV. Laboratory Accreditation

Indicate which organizations you are accredited by:

- | | | |
|-------------------------------|--------------------------------|--|
| <input type="checkbox"/> CAP | <input type="checkbox"/> COLA | <input type="checkbox"/> OTHER (specify) _____ |
| <input type="checkbox"/> AABB | <input type="checkbox"/> JCAHO | <input type="checkbox"/> OTHER (specify) _____ |

Name of Laboratory Director	Signature of Laboratory Director	Date
Name of Facility Commander	Signature of Facility Commander	Date
and Telephone Number of Testing Site Individual Completing This Form	DSN	Commercial

