

**Name of Organization:**

**Part 2A. ADDITIONAL ASSESSMENT PROGRAM LOCATION**

**A. Location where assessment is to be performed (complete a separate Supplemental Form 2A for each additional location):**

Name of Location: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City

Zip Code

Business Phone: (      ) \_\_\_\_\_ Fax: (      ) \_\_\_\_\_

**B. Dates and hours program will be in operation at this location (attach additional sheets if necessary):**

Dates	Hours	Dates	Hours

Note: Any changes in times, dates or location must be reported in writing to the NGHA program office at least 24 hours prior to the operation of the program.

**C. Nondiagnostic test being conducted at this location:**

( ✓ )	Test	Equipment Name	Manufacturer
<input type="checkbox"/>	Total Cholesterol		
<input type="checkbox"/>	High-Density Lipoprotein (HDL)		
<input type="checkbox"/>	Low-Density Lipoprotein (LDL)		
<input type="checkbox"/>	Triglycerides		
<input type="checkbox"/>	Blood Glucose		
<input type="checkbox"/>	Hemoglobin		
<input type="checkbox"/>	Dipstick Urinalysis		
<input type="checkbox"/>	Fecal Occult Blood		
<input type="checkbox"/>	Urine Pregnancy		
<input type="checkbox"/>			
<input type="checkbox"/>			

**D. List all employees who will participate in Nondiagnostic testing for this location (attach additional sheets if necessary):**

Name	Title	( ✓ ) Authorized to perform skin puncture *	
		Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

\* Note: Attach documentation of authorization to perform skin puncture for each individual checked "Yes" above. Include the name, signature and California Medical License number of the physician attesting. For licensed individuals submit a copy of valid license.

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