NGHA Provider Name: _____ **Date:** _____

For faxing purposes, please fax Part 2 to (951)358-5015. Please do not include a coversheet.

Part 2: ASSESSMENT PROGRAM

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
☐	Total Cholesterol		
☐	High Density Lipoprotein (HDL)		
☐	Triglycerides		
☐	Blood Glucose		
☐	Low Density Lipoprotein (LDL)		
☐			
☐			
☐			
☐			

D. List all employees for this location (attach additional sheets if necessary):

Name	Title	(✓) Authorized to perform skin puncture	
		Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Note: Submit documentation of authorization to perform skin puncture for each individual checked "Yes" above.

For NGHA Office Use Only:

Approved / Not Approved Date license issued: License No.:

Fee Received: Date Fee Submitted: _____ Check No.: _____

 Reset