

**NYS Limited Service Laboratory (LSL) and  
NYS HCV Rapid Testing Program (RTP) Annual Attestation**

Program: \_\_\_\_\_ Laboratory Director: \_\_\_\_\_

Program Oversight: \_\_\_\_\_ Date of Review: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Review Checklist</b>	<b>Details Inspected</b>	<b>Yes/No</b>	<b>Reviewed (Date/Initial)</b>
<b>LSL Registration Certificate</b>	LSL Registration Certificate is present, valid and supports facility testing.		
<b>Policies and Procedures (P&amp;P)</b>	P&P reviewed annually <ul style="list-style-type: none"> <li>• All testing sites have current version.</li> <li>• The procedure manual for conducting the HCV Rapid Antibody Test is up to date and includes listing of delegated Laboratory Director responsibilities.</li> <li>• The P&amp;P for the RTP is up to date.</li> </ul>		
<b>Quality Assurance (QA) Activities</b>	Master Patient Testing Logs completed and reviewed.		
	Temperature Logs completed and reviewed (test and control kit storage and testing room).		
	Bloodborne Pathogen, Exposure & Infection Control Plans in place and compliant with regulatory standards.		
<b>Quality Control (QC) Records</b>	Control Logs completed and reviewed. <ul style="list-style-type: none"> <li>• Controls are run according to manufacturer guidelines and facility P&amp;P.</li> </ul>		
	Controls present, valid and properly labeled.		
	Corrective actions completed as appropriate/signed/reviewed/documented.		
<b>Competency Assessment</b>	Staff Competency Assessments conducted initially and at least annually thereafter. <ul style="list-style-type: none"> <li>• Documents tester's ability and knowledge to perform the HCV Rapid Test.</li> </ul>		
<b>Linkage to Care</b>	Referrals are tracked and documented.		
<b>Laboratory Review</b>	Supplies are in-date and labeled properly (kits, controls, blood collection tubes, etc.).		
	Evidence of inventory control system (adequate # of kits and controls per testing volume).		
	Laboratory space clean, orderly and clearly labeled.		
	PPE and disinfectant available.		

Comments: \_\_\_\_\_

A signature below is an attestation to the review of all the program areas listed above.

Laboratory Director Signature: \_\_\_\_\_ Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Program Oversight Signature: \_\_\_\_\_ Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_