

WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM
EMPIRE STATE PLAZA, P.O. BOX 509
ALBANY, NEW YORK 12201-0509
Telephone: (518) 485-5378 Fax: (518) 485-5414
E-Mail: CLEPCQ@health.state.ny.us
Web: www.wadsworth.org/clep

OFFICE USE ONLY	
Rec'd.	_____
Fee No.	_____
Entered	_____

APPLICATION FOR CERTIFICATE OF QUALIFICATION

Please refer to Part 19 of 10NYCRR, available on our website www.wadsworth.org/clep, for a description of Certificate of Qualification (CQ) requirements. Please read and follow the instructions carefully. Incomplete or incorrectly completed applications will delay processing.

Enclose a \$40.00 application fee payment, by check or money order made payable to "New York State Department of Health."

1. PERSONAL INFORMATION:

Last Name	First Name	MI	Any other name you are known by:	
Home Address/Street		City	State	ZIP
Telephone Number(s) w/Area Code				
(Home or Mobile)		(Work)		
E-mail Address		Social Security Number		

2. GRADUATE/PROFESSIONAL EDUCATION: List all medical schools, colleges and universities attended in chronological order whether or not a degree was received. Attach additional sheets as necessary in the same format.

Name of Medical School, College or University	Location City/State	Major Subjects	Attended		Degree
			From Mo/Yr	To Mo/Yr	

3. BOARD CERTIFICATION: Please list your board (re)certifications below and provide a copy of your certificate(s). Attach additional sheets as necessary in the same format.

Abbreviation of Board and Specialty (see list of abbreviations in instructions)	Date Certified	Date Recertified

4. QUALIFICATION FOR BOARD: Please indicate the specific training and/or experience which qualified you to sit for board examination. Descriptions of medical internships, residencies and fellowships should include the discipline and duration of each rotation. Attach additional sheets as necessary in the same format.

Institution	Title of Program	Discipline of Study	Dates of Study

5. LICENSURE: Physicians and dentists who are licensed and registered with the New York State Education Department must provide a copy of their current registration. Applicants licensed in another state must provide a copy of their current registration in their state of practice. Attach additional sheets as necessary in the same format.

Are you licensed and currently registered to practice medicine or dentistry in New York State? Yes No

If yes, Type of License	License Number	Year of Issuance	Date Registration Expires

Are you licensed and currently registered to practice medicine or dentistry in any other state? Yes No

If yes, Type of License	License Number	State	Year of Issuance	Date Registration Expires

6. POSTDOCTORAL TRAINING & EXPERIENCE: List all positions held in reverse chronological order. Attach additional sheets as necessary in the same format. Please explain any significant gaps in your employment history on a separate sheet.

Name and Address of Institution (most recent first)	Name of Director or Supervisor	Your Title	From (Mo/Yr)	To (Mo/Yr)

Describe laboratory experience / areas of responsibility. Provide specific dates for experience.

Name and Address of Institution (most recent first)	Name of Director or Supervisor	Your Title	From (Mo/Yr)	To (Mo/Yr)

Describe laboratory experience / areas of responsibility. Provide specific dates for experience.

7. CURRENT EMPLOYMENT: All sites of current employment must be listed along with job titles, whether as laboratory director or otherwise, and the name of your director or supervisor. If applicable, indicate NYS permit PFI number or CLIA number of laboratory. Attach additional sheets as necessary in the same format. Include a copy of your current curriculum vitae with a list of relevant publications.

Name, Address and Description of Institution	Name of Director or Supervisor	Your Title	Start Date (Mo/Yr)
PFI/CLIA#:			

Describe laboratory duties / areas of responsibility:

Name, Address and Description of Institution	Name of Director or Supervisor	Your Title	Start Date (Mo/Yr)
PFI/CLIA#:			

Describe laboratory duties / areas of responsibility:

8. CATEGORIES REQUESTED: Be sure to check off each category you seek to hold on your certificate.

CATEGORIES	REQUIREMENTS	
	MD, License, Registration, Recency and	Doctoral Degree, Recency and
<input type="checkbox"/> Andrology	ABP(CP) + 6 months training, or Experience	Experience
<input type="checkbox"/> Bacteriology	ABP(CP), ABP(MMB), ABMM, or Experience	ABMM or Experience
<input type="checkbox"/> Blood Banking Collection - Comprehensive	Experience	Experience
<input type="checkbox"/> Blood Banking Collection - Limited	ABP(CP), ABIM(Hem), or Experience	Experience
<input type="checkbox"/> Blood Lead	ABP(CP), ABCC(TC), ABFT, or Experience	ABCC(CC) or Experience
<input type="checkbox"/> Blood pH and Gases	ABP(CP), ABCC(CC), or Experience	ABCC(CC) or Experience
<input type="checkbox"/> Cellular Immunology – Leukocyte Function <input type="checkbox"/> Cellular Immunology – Non-malignant Leukocyte Immunophenotyping <input type="checkbox"/> Cellular Immunology – Malignant Leukocyte Immunophenotyping	Experience	Experience
<input type="checkbox"/> Clinical Chemistry	ABP(CP), ABCC(CC), or Experience	ABCC(CC) or Experience
<input type="checkbox"/> Clinical Toxicology	ABP(CP, ABCC(CC), ABCC(TC), ABFT, or Experience	ABCC(CC), ABCC(TC), ABFT or Experience
<input type="checkbox"/> Cytogenetics	Experience	Experience
<input type="checkbox"/> Cytopathology	ABP(AP)	
<input type="checkbox"/> Diagnostic Immunology	ABP(CP), ABP(MMB), ABMM, ABMLI, or Experience	ABMM, ABMLI, or Experience
<input type="checkbox"/> Endocrinology	ABP(CP), ABCC(CC), or Experience	ABCC(CC) or Experience
<input type="checkbox"/> Fetal Defect Markers	Experience	Experience
<input type="checkbox"/> Forensic Identity	Experience	Experience
<input type="checkbox"/> Forensic Toxicology	ABCC(TC), ABFT, or Experience	ABCC(TC), ABFT, or Experience
<input type="checkbox"/> Genetic Testing	Experience	Experience
<input type="checkbox"/> Hematology	ABP(CP), ABIM(Hem) + 6 months Training, or Experience	Experience
<input type="checkbox"/> Histocompatibility	Experience	Experience
<input type="checkbox"/> Histopathology-General <input type="checkbox"/> Oral Pathology <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Dermatopathology - Mohs testing only	ABP(AP) ABP(AP) ABP(AP) or ABP(DP) ABD	ABOMP (DDS only)
<input type="checkbox"/> Immunohematology	ABP(CP) or Experience	Experience
<input type="checkbox"/> Mycobacteriology	ABP(CP), ABP(MMB), ABMM, or Experience	ABMM or Experience
<input type="checkbox"/> Mycology	ABP(CP), ABP(MMB), ABMM, or Experience	ABMM or Experience
<input type="checkbox"/> Oncology - Soluble Tumor Markers <input type="checkbox"/> Oncology - Molecular and Cellular Tumor Markers	Experience	Experience
<input type="checkbox"/> Parasitology	ABP(CP), ABP(MMB), ABMM, or Experience	ABMM or Experience
<input type="checkbox"/> Parentage/Identity Testing	Experience	Experience
<input type="checkbox"/> Therapeutic Substance Monitoring/Quantitative Toxicology	ABP(CP), ABCC(CC), ABCC(TC), or Experience	ABCC(CC), ABCC(TC), or Experience
<input type="checkbox"/> Transfusion Services	ABP(BB/TM), ABP(CP) + 6 months Training, ABIM(Hem) + 6 months Training, or Experience	
<input type="checkbox"/> Trace Elements	Experience	Experience
<input type="checkbox"/> Transplant Monitoring	Experience	Experience
<input type="checkbox"/> Virology	ABMM, ABP(MMB), or Experience	ABMM or Experience

9. CERTIFICATION

- a. Have you ever had charges of administrative violations of local, state or federal laws, rules and regulations, including, but not limited to, the Public Health Law or related statutes, concerning the provision of health care services or reimbursement for such services sustained against you?
 Yes No
- b. Are such charges currently pending?
 Yes No
If yes, please provide details on a separate sheet and attach to this form.
- c. Have you ever been convicted of any crime, including, but not limited to, any offense related to the furnishing of or billing for clinical laboratory services and medical care, services or supplies, which is considered an offense involving theft or fraud?
 Yes No
- d. Are such charges currently pending?
 Yes No
If yes, please provide details on a separate sheet and attach to this form.
- e. Have you ever had any professional license or certification related to the practice of medicine, pathology, or laboratory science revoked, suspended, limited or denied?
 Yes No
If yes, please provide details on a separate sheet and attach to this form.
- f. I understand that under Section 577.1(a) of the Public Health Law my Certificate of Qualification may be revoked, suspended, limited or annulled if any fact is misrepresented in this application. Changes in any of the information in this application must be reported to the Clinical Laboratory Evaluation Program immediately. I also understand that additional penalties may apply if I misrepresent, conceal, or fail to disclose facts or information regarding my initial or continuing eligibility for a Certificate of Qualification, including conviction of any crime related to billing for laboratory services, omission or misrepresentation of material facts in applying for professional license, permit or registration related to the operation of a clinical laboratory or the concealment of ownership or controlling interest in a clinical laboratory. Further, I understand that offering a false instrument constitutes a crime under the Penal Law of the State of New York.

I understand that by signing this application form I agree to any investigations made by the Department of Health to verify or confirm the information I have given or any other investigation made by them in connection with my request for this Certificate of Qualification. If additional information is requested, I will provide it. Further, I understand that, should this application or my status be investigated at any time, I agree to cooperate in such an investigation.

In signing this application, I hereby certify that the information I have given the Department of Health as a basis for obtaining a Certificate of Qualification is true and correct.

Signature

Date

Submit this application, a current **curriculum vitae** and supporting documentation along with the \$40.00 application fee to:

Postal Service

Express Service

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