

## Notification of Change in Assistant Director

Telephone: (518) 485-5378 Fax: (518) 485-5414  
 E-mail: [CLEPCERT@health.state.ny.us](mailto:CLEPCERT@health.state.ny.us)  
 Web: [www.wadsworth.org/labcert/clep/clep.html](http://www.wadsworth.org/labcert/clep/clep.html)

Laboratory PFI Number:	Name and Address of Laboratory:

- CHANGE IN RESPONSIBILITY (Indicate name, CQ code, new categories below) Effective Date \_\_\_\_\_  
 CHANGE IN SCHEDULE (Indicate name, CQ code, new hours below) Effective Date \_\_\_\_\_  
 NEW APPOINTMENT (complete items below) Effective Date \_\_\_\_\_  
 END OF APPOINTMENT FOR DR.\* \_\_\_\_\_ Effective Date \_\_\_\_\_

\* Complete the block below to indicate the assistant director or director who will replace this individual as the responsible certificate holder for any permit categories that may no longer be covered as a result of this end of appointment.

**NEW ASSISTANT DIRECTOR** – Complete section below. The individual must hold a New York State Certificate of Qualification (CQ) in the appropriate categories.

First Name	M.I.	Last Name	CQ Code
Director Title:	Hours : From - To	Status	
<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Other _____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time M_____ T_____ W_____ TH_____ F_____ S_____ SU_____		
Home Address - Number and Street	City, Town or Village	State	Zip Code
Laboratory Permit Categories for which the Assistant Director will be responsible			

### OTHER EMPLOYMENT OF ASSISTANT DIRECTOR

NAME AND ADDRESS OF INSTITUTION/EMPLOYER	HOURS: FROM - TO	TITLE/DUTIES
	M_____ TU_____ W_____ TH_____ F_____ S_____ SU_____	
	M_____ TU_____ W_____ TH_____ F_____ S_____ SU_____	
	M_____ TU_____ W_____ TH_____ F_____ S_____ SU_____	

**NOTE: All signatures must be original. SIGNATURE STAMPS WILL NOT BE ACCEPTED.** By signing this form, I hereby certify that the information given is true and correct. I also attest that I have reviewed a copy of the most current laboratory application on file with the department for this laboratory, and have read all applicable clinical laboratory regulations and quality control standards.

\_\_\_\_\_  
 Date                                      Signature, Laboratory Director                                      Name, Laboratory Director (Print)

\_\_\_\_\_  
 Date                                      Signature, Assistant Laboratory Director                                      Name, Assistant Director (Print)