

Notification of Change in Laboratory Director

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

Laboratory PFI Number:	Name and Address of Laboratory:

FORMER LABORATORY DIRECTOR: _____

Effective date former directorship ended: _____ **Effective date new directorship began or will begin:** _____

Will former director be remaining as assistant director? Yes No

NEW LABORATORY 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		
<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 Director will be responsible			

OTHER EMPLOYMENT OF 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. I also assume responsibility for any patient service centers currently operated by this laboratory.

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

Date Signature, Owner/Representative Name, Owner/Representative