New York State Department of Health
Clinical Laboratory Evaluation Program
Wadsworth Center
Empire State Plaza
P.O. Box 509
Albany, New York 12201-0509

FOR OFFICE USE ONLY

Received_____

Entered_____

NYS Registration No._____

INITIAL APPLICATION CYTOTECHNOLOGIST REGISTRATION

Please type or print the information requested below and return to the address printed above.

SECTION I - GENERAL INFORMATION

SOCIAL SECURITY # (Required under NYS Tax Law - See Instructions)

FIRST NAME MI

LAST NAME

ANY OTHER NAME YOU ARE KNOWN BY

HOME ADDRESS

CITY

STATE ZIP CODE ------

ASCP REGISTRY NUMBER C T -

YEAR OBTAINED

YEARS OF EXPERIENCE FULL TIME PART TIME

OTHER REGISTRY NUMBER

YEAR OBTAINED

SECTION II – CYTOTECHNOLOGIST EDUCATION

NAME OF COLLEGE

ADDRESS

CITY

STATE ZIP CODE ------

YEAR GRADUATED SEMESTER HOURS DEGREE EARNED

AA/AS BA/BS OTHER

NAME OF CYTOLOGY TRAINING PROGRAM

ADDRESS

CITY

STATE ZIP CODE ------

YEAR GRADUATED

SECTION III – CYTOTECHNOLOGIST EMPLOYMENT

If currently employed at a laboratory applying for or holding a New York State permit, please provide the facility's PFI, name, address, your hours and days of employment and employment status:

LABORATORY PFI

NAME OF FACILITY

ADDRESS

CITY

STATE ZIP CODE –

START DATE (MM/DD/YY) / /

Your working days and hours at this facility:

MON ____to____ TUE ____to____ WED ____to____ THUR ____to____ FRI ____to____ SAT ____to____ SUN ____to____

EMPLOYMENT STATUS FULL-TIME ☐ PART-TIME ☐ PER DIEM ☐

ACKNOWLEDGEMENT: I HAVE RECEIVED AND READ SECTIONS 58 -1.12 AND 58-1.13 OF 10 NYCRR AND AM AWARE OF THE REQUIREMENTS OF REGISTRATION. FURTHER, UNDER THE PENALTIES OF PERJURY, I DECLARE AND AFFIRM THAT THE STATEMENTS MADE IN THIS APPLICATION, INC LUDING ACCOMPANYING STATEMENTS AND TRANSCRIPTS, ARE TRUE, COMPLETE AND CORRECT. I FURTHER UNDERSTAND THAT ANY FALSE OR MISLEADING INFORMATION IN, OR IN CONNECTION WITH MY APPLICATION MAY BE CAUSE FOR DENIAL OR REVOCATION OF MY REGISTRATION.

_____ _____

SIGNATURE OF APPLICANT DATE