

Andrology

E-mail: CLEPCQ@health.ny.gov
 Web: www.wadsworth.org/regulatory/clep

Instructions: Complete in full for testing you personally performed, supervised and/or directed. Obtain all appropriate signatures and submit this form along with any applicable letters of documentation to the NYS Department of Health at the address listed above.

Name _____ CQ Code (if known) _____

Name of facility _____ PFI/CLIA# _____

Test	Dates MM/YY-MM/YY	Volume for dates listed	FDA-Approved* Yes/No
Semen analysis			
Other Andrology tests (specify)			

*FDA-Approved assays include those cleared (510k), approved (PMA), exempted, or with Emergency Use Authorization (EUA) by the United States Food and Drug Administration (FDA) that have not been modified to change the procedure or the intended use. Investigational Use Only (IUO)-labeled tests are ONLY included when utilized under a specific FDA Investigational Device Exemption (IDE).

Is/was andrology testing performed under your direct supervision? Yes No

If No, under whose direct supervision (physician or doctoral level director) is/was this performed?

Detail your responsibilities:

The applicant and supervisor/director must print and sign their names below to attest that the testing above was performed by and/or under direct supervision by the applicant.

 Print applicant name Applicant signature Date

 Print supervisor/director name Supervisor/director signature Date

 Supervisor/director's relationship to applicant (e.g. direct supervisor) and how this allows attestation of the applicant's training and/or experience