NEW YORK STATE DEPARTMENT OF HEALTH

Certificate of Qualification Questionnaire

Clinical Laboratory Evaluation Program Biggs Lab – Wadsworth Center Empire State Plaza Albany, NY 12237

Blood Banking Collection - Comprehensive

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

	atures and subr	testing you persona nit this form along w ddress listed above	ith any app				_	
Name	CQ Code (if known)							
ame of facility PFI/CLIA#								
Dates involved in collection at the ab	ove facility (MM						_	
Number of collections each year	20*	20 2	.0	20	20	20		
Allogeneic whole blood								
Autogeneic whole blood								
Pheresis components **								
* If current year exceeds 1000 total units ** Do not include therapeutic pheresis pr		d not be entered.					j	
ls/was collection under your direct supe	rvision? Yes	No						
Describe your responsibilities pertinent to	o blood collection	:						
Have you taken a refresher course on do If you wish to request the optional area of Board Certified in CP? Is the testing board certified?	of testing for infec Yes (If Yes,		ine)	Yes Wi No No	hen?		No	
If performed onsite, is the testing	g under your dired	ct supervision? Ye	es No	(If No, explai	n your responsibi	lities):		
If testing is performed offsite but pertinent experience:	you still wish to b	pe considered for a CC) for transmi	ssible disease	testing, describe	your		
The applicant and supervisor/director mu and/or under direct supervision by the applicant supervision by the applicant supervision by the applicant supervision by the applicant supervision supervision by the applicant supervision supe		their names below to a	attest that th	e collections a	nd testing above	were performed b	у	
Print applicant name	Ap	pplicant signature			Date			
Print supervisor/director name	Su	Supervisor/director signature			Date	Date		

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