NEW YORK STATE DEPARTMENT OF HEALTH
Clinical Laboratory Evaluation Program
E-mail: CLEPCQ@health.ny.gov
Web: www.wadsworth.org/regulatory/clep

Technical Director
Certificate of Qualification
Questionnaire

Andrology

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