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

Transfusion Services

Instructions:	Complete in full for transfusion services 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#_____

Dates involved in transfusion services at the above facility (MM/YY-MM/YY)_____

What percentage of time is/was spent in the blood bank/transfusion service? _____ %

Is/was transfusion service under your **direct** supervision? ☐ Yes ☐ No

Describe transfusion-related activities, including transfusion committee, antibody panels, transfusion reaction work-ups, consultation with physicians:

If using residency or fellowship training to fulfill requirements, describe blood bank rotations, including dates, duration and duties:

Describe other relevant experience:

The applicant and supervisor/director must print and sign their names below to attest that the transfusion services above were 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