NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center - Clinical Laboratory Evaluation Program Empire State Plaza
Albany, NY 12237
E-mail: CLEPCQ@health.ny.gov
Web: www.wadsworth.org/regulatory/clep

Certificate of Qualification Questionnaire

Blood Banking Collection - Comprehensive

Instructions: Complete in full and obtain all appropriate signatures. Submit this form along with any applicable letters of documentation to the NYS Department of Health at the address listed above.

Name _____

Name of collection facility _____

Dates involved in collection at the above facility _____

Number of collections each year	20___ *	20___	20___	20___	20___	20___
Allogeneic whole blood						
Autogeneic whole blood						
Pheresis components **						

* If current year exceeds 1000 total units, other years need not be entered.
** Do not include therapeutic pheresis procedures.

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

Describe your responsibilities pertinent to blood collection:

Have you taken a refresher course on donor collection and testing within the past six years? ☐ Yes When? _____ ☐ No

If you wish to request the optional area of testing for infection disease markers:

Board Certified in CP? ☐ Yes (If Yes, skip to the signature line) ☐ No
Is the testing board certified? ☐ Yes (If Yes, specify analytes below) ☐ No

If performed onsite, is the testing under your direct supervision? ☐ Yes ☐ No (If No, explain your responsibilities):

If testing is performed offsite but you still wish to be considered for a CQ for transmissible disease testing, describe your pertinent experience:

The applicant and supervisor/director must sign and print their names below.

Print applicant name	Applicant signature	Date
Print supervisor/director name	Supervisor/director signature	Date