NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM

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

OFFICE USE ONLY
Rec'd._____
Fee No._____
Entered_____

APPLICATION FOR CERTIFICATE OF QUALIFICATION

COVID-19 RESPONSE

This application is specifically to request a Certificate of Qualification in Virology limited to COVID-19 testing. The qualified applicant must meet the requirements for a laboratory director for high complexity testing as provided in 42 CFR §493.1441.

If you will be seeking a Certificate of Qualification for additional virology testing, or in any other category, please submit form DOH-238 and provide all supporting documentation requested.

Enclose a $40.00 application fee payment, by check or money order made payable to "New York State Department of Health" and a current curriculum vitae (CV) with this application.

1. **PERSONAL INFORMATION : Please provide your home address, as a Certificate of Qualification is a personal credential.**

Last Name	First Name	MI

Social Security Number	Any other name you are known by:

Home Address/Street	City	State	ZIP

Telephone Number(s) w/Area Code	
(Home or Mobile)	(Work)

Home Email Address	Work Email Address

2. GRADUATE/PROFESSIONAL EDUCATION: List the college or university where your doctoral degree(s) was(were) conferred.

Name of Medical School, College or University	Location City/State	Major Subjects	Attended From (Mo/Yr)	Attended To (Mo/Yr)	Degree

3. PHYSICIAN LICENSURE: List your license information and provide a copy of your current registration issued by your state of practice.

State	License Number	Year of Issuance	Expiration Date

4. BOARD CERTIFICATION: List your board (re)certifications below and provide a copy of your certificate(s). Boards currently approved by the federal Health and Human Services will be recognized.

Board and Specialty	Date Certified	Date Recertified

APPROVED HHS BOARDS:

- American Board of Bioanalysts – High Complexity Laboratory Director
- American Board of Bioanalysts – Public Health Laboratory Director
- American Board of Clinical Chemistry
- American Board of Forensic Toxicology
- American Board of Histocompatibility and Immunogenetics
- American Board of Medical Genetics and Genomics
- American Board of Medical Laboratory Immunology
- American Board of Medical Microbiology
- American Board of Pathology
- American Osteopathic Board of Pathology
- National Registry for Clinical Chemists

5. COVID-19 TESTING EXPERIENCE:
Please complete the table below.

Antigen Detection	**Dates** (mo/yr – mo/yr)	**Tests per year**	**Instrument/ Platform**	**Method/ Chemistry**	**Test holds FDA EUA?**
					◯ **Y** ◯ **N**
					◯ **Y** ◯ **N**
					◯ **Y** ◯ **N**
Molecular	**Dates** (mo/yr – mo/yr)	**Tests per year**	**Instrument/ Platform**	**Method/ Chemistry**	**Test holds FDA EUA?**
					◯ **Y** ◯ **N**
					◯ **Y** ◯ **N**
					◯ **Y** ◯ **N**

6. EMPLOYMENT DURING THE PREVIOUS SIX YEARS: All sites of employment must be listed along with job title and the name of your director or supervisor. If applicable, indicate NYS permit PFI number or CLIA number of laboratory. Add additional pages as necessary. Explain any significant gaps in your employment history on a separate sheet. Include a copy of your current curriculum vitae with a list of relevant publications.

PFI/CLIA#	Name of Institution		
Institution Address		**Institution Description**	
Name of Director or Supervisor	**Your Title**	**Start Date (Mo/Yr)**	**End Date (Mo/Yr)**
Describe laboratory duties / areas of responsibility:			

7. CERTIFICATION

a. Have you ever had charges of administrative violations of local, state or federal laws, rules and regulations, including, but not limited to, the Public Health Law or related statutes, concerning the provision of health care services or reimbursement for such services sustained against you?

◯ **Yes** ◯ **No**

b. Are such charges currently pending?

◯ **Yes** ◯ **No**

If yes, provide details on a separate sheet and attach to this form.

c. Have you ever been convicted of any crime, including, but not limited to, any offense related to the furnishing of or billing for clinical laboratory services and medical care, services or supplies, which is considered an offense involving theft or fraud?

◯ **Yes** ◯ **No**

d. Are such charges currently pending?

◯ **Yes** ◯ **No**

If yes, provide details on a separate sheet and attach to this form.

e. Have you ever had any professional license or certification related to the practice of medicine, pathology, or laboratory science revoked, suspended, limited or denied?

◯ **Yes** ◯ **No**

If yes, provide details on a separate sheet and attach to this form.

f. In signing this application, I hereby certify that the information I have given the Department of Health as a basis for obtaining a Certificate of Qualification is true and correct. I understand that under Public Health Law my Certificate of Qualification may be denied, revoked, suspended, limited or annulled if any fact is misrepresented in this application. I also understand that additional penalties may apply if I misrepresent, conceal, or fail to disclose facts or information regarding my initial or continuing eligibility for a Certificate of Qualification, including conviction of any crime related to billing for laboratory services, omission or misrepresentation of material facts in applying for professional license, permit or registration related to the operation of a clinical laboratory or the concealment of ownership or controlling interest in a clinical laboratory.

Changes in any of the information in this application must be reported to the Clinical Laboratory Evaluation Program immediately, to include changes in physical or email address.

I also agree to submit to any investigation made by the Department of Health to verify the information provided in this application, any other investigation in connection with this application, and/or any complaint filed with the Department. If additional information is requested, I agree that it will be provided in a timely manner.

Signature _____ **Date**

NOTE: ALL SIGNATURES MUST BE ORIGINAL. SIGNATURE STAMPS AND ELECTRONIC SIGNATURES WILL NOT BE ACCEPTED.

Submit this application with the $40.00 application fee and current CV to:

Postal Service
CLINICAL LABORATORY EVALUATION PROGRAM
WADSWORTH CENTER
NEW YORK STATE DEPARTMENT OF HEALTH
EMPIRE STATE PLAZA
ALBANY, NEW YORK 12237

Express Service
CLINICAL LABORATORY EVALUATION PROGRAM
WADSWORTH CENTER
NEW YORK STATE DEPARTMENT OF HEALTH
EMPIRE STATE PLAZA
P1 SOUTH, LOADING DOCK J
ALBANY, NY 12237