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

Certificate of Qualification Questionnaire

Fetal Defect Markers

Instructions: Complete in full for testing that you have 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 _____

Analyte	Length of experience (years/mos)	Number of patient specimens analyzed	Methods:	Technique:			
			Manufacturer	Lumin-escence	EIA	RIA	Other
AFP				☐	☐	☐	
uE3				☐	☐	☐	
Total hCG				☐	☐	☐	
Beta (β)–hCG				☐	☐	☐	
Inhibin-A				☐	☐	☐	
PAPP-A				☐	☐	☐	
Other (list below)							
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	

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Select all screens you have personally performed, supervised, or directed:

☐ 1. Combined testing: 1st Trimester NT plus PAPP-A, hCG

☐ 2. Double testing: 2nd Trimester AFP, and total hCG or β-hCG

☐ 3. Triple testing: 2nd Trimester AFP, uE3, and total hCG or β-hCG

☐ 4. Quad testing: 2nd Trimester AFP, uE3, Inhibin-A, and total hCG or β-hCG

☐ 5. Integrated test: 1st Trimester (10-13 weeks) NT plus PAPP-A and 2nd Trimester (14-20 weeks) Quad testing

☐ 6. Serum Integrated: 1st Trimester (10-13 weeks) PAPP-A (non-NT) and 2nd Trimester (14-20 weeks) Quad testing (a single result only)

*NT = Nuchal translucency

Describe any modifications of the above screens you have personally performed, supervised, or directed:

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

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