

**Mycology**

**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 \_\_\_\_\_

Tests	Specimen Source	Dates (MM/YY-MM/YY)	Tests per Year	Instrument/Platform and Method/Chemistry	FDA Approved (Y/N)
Direct examinations (KOH mounts, stained smears, etc.)					
<b>Microscopic Examinations</b>					
Yeasts					
Molds					
<b>Yeast Identification</b>					
Conventional Methods					
Commercial Systems					
<b>Mold Identification by Conventional Methods</b>					
<i>Aspergillus</i> species					
Dermatophytes					
Dematiaceous					
Dimorphs					
Hyaline fungi					
Zygomycetes					
<b>Molecular Detection and Characterization (specify organism(s))</b>					
<b>Antifungal Susceptibility Testing (specify organism(s))</b>					
<b>Antigen Testing (specify organism(s))</b>					

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

\_\_\_\_\_ Applicant signature \_\_\_\_\_ Date \_\_\_\_\_  
 Print applicant name

\_\_\_\_\_ Supervisor/director signature \_\_\_\_\_ Date \_\_\_\_\_  
 Print supervisor/director name