

# Parasitology

E-mail: [CLEPCQ@health.ny.gov](mailto:CLEPCQ@health.ny.gov)  
 Web: [www.wadsworth.org/regulatory/clep](http://www.wadsworth.org/regulatory/clep)

Instructions: Complete in full and obtain all appropriate signatures as indicated on page 2. This form along with any applicable letters of documentation should be submitted to the NYS Department of Health at the address listed above.

Name \_\_\_\_\_ CQ Code (if known) \_\_\_\_\_

Name of facility \_\_\_\_\_

If your recent experience is with urogenital wet mounts only, skip to section 2.

## SECTION 1 – General Parasitology

	Assay	Manufacturer or Platform	Test volume and year 20____	Test volume and year 20____	Test volume and year 20____
Intestinal	<i>eg. GI Panel</i>	<i>Biofire</i>			
Bloodborne	<i>eg. Giemsa Stain</i>	<i>Trend</i>			
Helminths					
Arthropods					

Describe your responsibilities with respect to parasitology testing:

Is/Was all of the testing listed in the above table performed under your direct supervision? \_\_\_ Yes \_\_\_ No

If No, what percentage was under your direct supervision? \_\_\_\_\_ Under whose direct supervision (doctoral level director) is/was the remaining testing performed? \_\_\_\_\_

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**SECTION 2 – Wet Mounts**

	20__	20__	20__
Total Wet Mounts			
Number of Positive			

Describe your exact responsibilities pertinent to performing urogenital wet smears for the presence of *Trichomonas vaginalis*:

Are/Were all of the wet mounts listed above performed under your direct supervision? \_\_\_ Yes \_\_\_ No

If No, what percentage was under your direct supervision? \_\_\_\_\_ Under whose direct supervision (doctoral level director) is/was the remaining testing performed? \_\_\_\_\_

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