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

Transfusion Services

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 blood bank/transfusion service _____

Dates transfusion service at the above facility _____

What percentage of time is/was spent in the blood bank/transfusion service? _____ %

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

Describe transfusion-related activities, including transfusion committee, antibody panels, transfusion reaction work-ups, consultation with physicians:

If using residency or fellowship training to fulfill requirements, describe blood bank rotations, including dates, duration and duties:

Describe other relevant 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