The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Clinical Laboratory Technologist Form 4 Certification of Experience

ONLY use this form to document experience required by Form 2 (if necessary). You must document a total of two years of professional experience. Copy this form as needed.

Applicant Instructions

1. Complete Section I. Be sure to sign and date item 8.

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2. Send the entire form to the Clinical Laboratory Director of the clinical laboratory where you were employed to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Sec	ction I: Applicar	nt Information						
1.	Social Security (Leave this blank	Number if you do not have a U.S. Social Security Number)	2.	Birth Date	Month	Day	Year	
3.	Print Name	Last						
		First			5.	Telephone/Em	ail Address	
		Middle				Daytime Pho Home		
<u>Licensee</u> business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.								
4.	Mailing Addres	s Home or Business				Area Code	Phone	
	•	fy the Department promptly of any address or nam	e cha	anges)			s (please print clearly) or Business	
	Line 1					_		
	Line 2						_	
	Line 3				6.	New York Stat (Driver or Non-	e DMV ID Number	
	City					(Direct of Noise	ישויטוועכו ושי	
	State	ZIP Code					nk if you do not have a	
	Country/ Province					New York State	e DMV ID Number)	
7.	Name of Clinical	Laboratory Director I am asking to complete this form						
	Name of clinical laboratory where employed:							
	Address of clinical laboratory where employed:							
	Duration of experience: Date beginning Date ending Total clock hours:							
	The experience I am documenting on this form was gained while (check one):							
	I was working in a clinical laboratory while licensed as a clinical laboratory technician (check one): In New York State. New York State license number:							
In another jurisdiction. You must submit a Form 3. OR								
	I was workir	I was working in a clinical laboratory while certified by the American Society for Clinical Pathology (ASCP) Board of Certification as a Medical Laboratory Technician with the following credentials ASCP (MLT) or ACSPi (MLT).						
8.	I request and give my permission to the individual listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure. I understand that additional information may be requested, if needed, to ensure that I have met the requirements for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of provisional permit and may result in criminal prosecution.							
	Signature	gnature Date						

Section II: Certification of Experience							
Instructions to the Clinical Laboratory Director: Complete A and B, sign and date the affirmation and send the entire form along with ANY additional information directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if submitted by the applicant.							
Na	ame of the applicant						
	(see Section I, item 3)						
A.	Qualifications						
	I am a Clinical Laboratory Director as defined below	Yes No					
	Definition: A "Clinical Laboratory Director" means a "person who is responsible for admoperation of a clinical laboratory or blood bank, including the supervision of procedures						
В.	Experience Information						
	Did the above named applicant complete such experience as indicated in Section I, item 7?	Yes No					
	Name of setting where experience took place						
	Address of setting where experience took place						
	Dates of Experience From to to day yr day yr.	Total clock hours:					
	derstand that any false or misleading information on this form, or related to verification of this arges of misconduct and/or criminal prosecution.	applicant's experience, may be cause for					
Si	gnature	Date					
Pr	rint Name						
Tit	le						
Ad	ddress						
Τe	elephone Fax						
Er	mail						
	eturn Directly to: New York State Education Department, Office of the Professions, Division of boratory Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000, or by email to dp						

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