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 Technician Form 3C
Verification of Certification by the American Society for Clinical Pathology

ONLY Use This form to verify certification by the American Society for Clinical Pathology.

Applicant Instructions

1. Complete Section I. Be sure to sign and date item 8.
2. Send the entire form to the national certifying body for completion of Section II. Be sure to include any fee required by that certifying authority.

Section I: Applicant Information

1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. Print Name Last
First
Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business
Area Code Phone

Email Address (please print clearly)
☐ Home or ☐ Business

Licensee 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 Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)
Line 1
Line 2
Line 3
City
State ZIP Code
Country/ Province

6. New York State DMV ID Number (Driver or Non-Driver ID)
(Leave this blank if you do not have a New York State DMV ID Number)

7. Print your name as it appears on the certificate issued by the American Society for Clinical Pathology.

Name _____

Professional title on certificate issued _____

8. I request and give my permission to the American Society for Clinical Pathology to complete the information on this form and send any documentation requested, including that requested on this form, to the New York State Education Department at the address at the end of this form. 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 licensure and may result in criminal prosecution.

_____ _____
Signature Date

Section II: Verification of Certification by the American Society for Clinical Pathology (Please Print)

Instructions to the American Society for Clinical Pathology (ASCP): If the applicant was certified by the ASCP, complete items 1-4, sign and date the certification and return both pages of this form in an official envelope **directly** to the Office of the Professions at the address at the end of this form. **This form will not be accepted if returned by the applicant.** Attach additional sheets if necessary.

1. Name of the applicant _____
(see Section I, item 8)

2. Professional title on certificate _____

Certificate number _____ Date of certification ____ ____ ____
mo. day yr.

4. A. Has the applicant been subject to any disciplinary action? ☐ Yes ☐ No

B. Are any charges pending against this certificate? ☐ Yes ☐ No

If the answer to either A or B is "yes", please attach a complete explanation with any supporting documentation.

Certification

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted above or in any attachments, this certifying authority has never taken any disciplinary action against this person and that in so far as the licensing/certifying authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

_____ _____
Signature Date

Print Name _____

Title _____

Address _____

_____

Seal

Telephone _____

Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Clinical Laboratory Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000. **OR, Submit this form to the Department by E-mail at DPLSVerif@nysed.gov.**