

Clinical Laboratory Technologist Restricted License Form 4A

Certification of Completion of a Training Program in Flow Cytometry/Cellular Immunology

Applicant Instructions

1. Complete Section I and sign and date item 8.
2. Send the entire Form 4A to the Clinical Laboratory Director of the flow cytometry/cellular immunology training program you completed and ask them to complete Section II and submit it 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.**

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

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.

- Area Code Phone
Email Address (please print clearly)
 Home or Business

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. Name of the Clinical Laboratory Director to which this form is being sent _____

8. I request and give my permission to the individual listed in item 7 above to complete Section II of this form and submit 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 have reviewed the rules and regulations of the New York State Department of Health and the U.S. Department of Health and Human Services, relating to practice as a clinical laboratory technologist in New York State, in accordance with written guidance from the Department.

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: Certification of Completion

Instructions to the Clinical Laboratory Director: Complete this section, and complete and sign the Affirmation. Return the entire 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.**

Name of the applicant _____
(see Section I, item 3)

I am attesting that the applicant named above has completed a training program for flow cytometry/cellular immunology which included:

Knowledge of:

The technique for counting, sorting, and characterization of cells suspended in a fluid stream based on their physical properties and expression of cell surface molecules;

The program also included:

- general laboratory principles and skills;
- infection control and aseptic technique;
- quality control and quality assurance;
- instrumentation and equipment;
- the basic principles of flow cytometry, including specimen preparation, fluidics and electronics;
- fluorochrome selection;
- antibody selection;
- the design of flow cytometry procedures, including routine standardization and quality management; and
- specific clinical applications.

as described in the previously submitted **Clinical Laboratory Technologist Restricted License In Flow Cytometry/Cellular Immunology Form 4.**

Name of Clinical Laboratory Director _____

Certificate of Qualification Identification Number _____

Authorized category of practice _____

Name and address of the Clinical Laboratory in which the training program is provided. If the entity that is responsible for the services provided is not the same, include the name and address of that entity.

Affirmation - To be completed by the Clinical Laboratory Director

I declare and affirm under penalty of perjury that the statements made in the foregoing application, including any attached statements, are true, complete and correct.

Signature of Clinical Laboratory Director _____ Date _____

Print Name _____

Address _____

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.