

Clinical Laboratory Technologist Restricted License Form 4

Attestation of Training Program Content in Stem Cell Process

Applicant Instructions

Complete Section I. Review and complete Section II with the Clinical Laboratory Director of the stem cell process training program in which you wish to participate. Be sure to sign and date the attestation. Ask the Clinical Laboratory Director to return the entire form to the Office of the Professions at the address at the end of the form. **This form will not be accepted if returned 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

6. New York State DMV ID Number
(Driver or Non-Driver ID)

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)

(Leave this blank if you do not have a New York State DMV ID Number)

Line 1

Line 2

Line 3

City

State

ZIP Code

Country/
Province

5. Telephone/Email Address

Daytime Phone

Home or Business

Email Address (please print clearly)

Home or Business

Area Code

Phone

Section II: Program Information

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.

Section II: Program Information (Continued)

Both the applicant and Clinical Laboratory Director must initial each area listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	Applicant (Initial)	Clinical Laboratory Director (Initial)
The training program shall include knowledge of:		
• stem cell biology.	_____	_____
The program shall also include, but need not be limited to:		
• general laboratory principles and skills;	_____	_____
• infection control and aseptic technique;	_____	_____
• instrumentation and equipment;	_____	_____
• quality control and quality assurance;	_____	_____
• laboratory mathematics;	_____	_____
• the process of handling stem cell specimens in the laboratory;	_____	_____
• enumeration and characterization of stem cells;	_____	_____
• ABO/Rh confirmatory typing; and,	_____	_____
• reagent preparation.	_____	_____

Description of Program: Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

Applicant Attestation (This form must bear an original signature)

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

Applicant Signature _____
Date
Print Name _____

Clinical Laboratory Director Attestation (This form must bear an original signature)

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

Clinical Laboratory Director Signature _____
Date
Print Name _____

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.