

## Histotechnologist 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.
2. Send the entire form to the Clinical Laboratory Director of the clinical or research 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.**

### 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.**

4. Mailing Address    Home or  Business  
*(You must notify the Department promptly of any address or name changes)*  
    Line 1  
    Line 2  
    Line 3  
    City  
    State              ZIP Code  
    Country/  
    Province
5. Area Code              Phone  
    Email Address (please print clearly)  
         Home or  Business
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 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: \_\_\_\_\_  
                                    mo. day yr.                      mo. day yr.  
    The experience I am documenting on this form was gained while (check one):  
         I was working in a clinical laboratory while licensed as a histotechnician (check one):  
             In New York State. New York State license number:  
             In another jurisdiction. **You must submit a Form 3.**  
    **OR**  
         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 (HT) or ACSPI (HT).

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 \_\_\_\_\_

Date \_\_\_\_\_

**Section II: Certification of Experience**

**Instructions to the Clinical Laboratory Director/Principal Researcher:** 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.**

Name 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 administration of the technical and scientific operation of a clinical laboratory or blood bank, including the supervision of procedures and reporting of findings of tests".*

**B. 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 \_\_\_\_\_ Total clock hours: \_\_\_\_\_  
mo. day yr. mo. day yr.

**Affirmation of Clinical Laboratory Director**

I have reviewed the information presented by the applicant on this form. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work experience and ability and that the work experience described by the applicant is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Title \_\_\_\_\_

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, or by email to [dplsexperience@nysed.gov](mailto:dplsexperience@nysed.gov).