

## Clinical Laboratory Technologist Restricted License Form 4

### Attestation of Training Program Content in Cytogenetics

#### Applicant Instructions

Complete Section I. Review and complete Section II with the Director of the Cytogenetics Training Program in which you want to participate. Be sure to sign and date the applicant attestation and ask the Training Program Director to return all pages of the 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
5. Telephone/Email Address  
Daytime Phone  
 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 \_\_\_\_\_
- 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)*

#### Section II: Training Program Information

1. Name of Clinical Laboratory offering the Training Program \_\_\_\_\_  
Address of Clinical Laboratory \_\_\_\_\_  
New York State Department of Health (DOH) Clinical Laboratory Permit Number \_\_\_\_\_  
Indicate whether the Cytogenetics testing is authorized by the DOH issued Clinical Laboratory Permit  
 Yes     No
2. Name of Cytogenetics Training Program Director \_\_\_\_\_  
Job Title \_\_\_\_\_  
Contact Email Address \_\_\_\_\_  
Contact Telephone Number \_\_\_\_\_  
Check Each that apply  
 I hold a DOH issued Laboratory Director Certificate of Qualification in Cytogenetics.  
 I am the Clinical Laboratory Director of the Clinical Laboratory described above.  
 I am a sole Assistant Clinical Laboratory Director at the Clinical Laboratory described above.

**Section II: Training Program Information (Continued)**

3. The applicant and the training program director must initial below indicating that all the following training program requirements will be met.

The Training Program will cover: (a) human genetics and clinical cytogenetics, including chromosome structure/behavior and its correlation with phenotype; (b) laboratory principles and skills, including infection control, aseptic technique, quality control, quality assurance, use and maintenance of instruments, and laboratory mathematics; (c) specimen processing, including sample preparation, culturing, harvesting, slide preparation, staining, and chromosomal banding techniques; (d) chromosome analysis and imaging, including recognition and interpretation of chromosomal abnormalities; and (e) molecular cytogenetic testing methods, such as chromosomal microarray analysis, and/or metaphase and interphase fluorescence in situ hybridization (FISH). The Training Program will **only** include hands-on laboratory services authorized by a Department of Health Clinical Laboratory permit in the category of Cytogenetics.

Applicant Initials \_\_\_\_\_ Training Program Director Initials \_\_\_\_\_

The Training Program will be at least 1750 hours (1 year) and will not involve any testing or procedures on specimens which are outside the restricted license category of Cytogenetics.

Applicant Initials \_\_\_\_\_ Training Program Director Initials \_\_\_\_\_

The Training Program will provide continuous on-site personal supervision and training by qualified staff whenever the applicant performs any clinical laboratory services. The staff shall meet the following qualifications: (1) hold a DOH issued Laboratory Director Certificate of Qualification in *Cytogenetics* or (2) be a New York State licensed clinical laboratory technologist or physician who qualifies as a "laboratory supervisor" under DOH regulations (10 NYCRR section 58-1.4) and who is authorized by the Clinical Laboratory to perform cytogenetic testing and authorized by the Training Program Director to train or supervise the applicant.

Applicant Initials \_\_\_\_\_ Training Program Director Initials \_\_\_\_\_

**Description of Program:** Describe how the Training Program will be taught (i.e., readings, lectures, supervised hands-on clinical practice) including educational resources (i.e., specific SOPs, textbooks, online coursework) to be used to teach each required topic described in Item 3 above as well as any additional cytogenetics topics to be covered by the Training Program. Describe how the Training Program will evaluate the trainee's learning and competency for each Training Program topic. The Training Program description should also include a tentative amount of time training will occur each week and the plan for supervising the trainee during hands-on training in the clinical laboratory, including the positions of staff involved in supervision.

**Applicant Attestation**

I hereby attest that the information I provided on this form is accurate and complete, and that I understand the above-described training program requirements must be met to successfully complete the training program.

\_\_\_\_\_  
Applicant Signature Date

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

**Training Program Director Attestation**

I hereby attest that the information I provided on this form is accurate and complete, and that I understand the above-described training program requirements must be met for the applicant to successfully complete the training program.

\_\_\_\_\_  
Training Program 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.