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 Technologist Restricted License Form 4A

Certification of Completion of a Training Program in Histocompatibility

Applicant Instructions

Complete Section I. Be sure to sign and date item 8. Send this form to the Director of the Histocompatibility Training Program that you completed and ask the Training Program Director to complete Section II and 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

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

5. Telephone/Email Address

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

Area Code Phone

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 Director of the Histocompatibility Training Program that you completed

8. I have successfully completed the Histocompatibility Training Program as described in Section II of this form. I request and give my permission to the individual listed in item 7 above to complete Section II of this form and return it to the New York State Education Department at the address at the end of the form, and to release any other information requested by the State Education Department in connection with my application.

I hereby attest that the information in Section I is true and accurate. I understand that any false or misleading information provided in connection with my application may be cause for denial or loss of licensure or criminal prosecution.

Signature Date

Section II: Certification of Training Program Completion

Training Program Director Instructions: Complete Section II. Be sure to sign and date the Affirmation. 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.**

Name of the applicant _____

(see Section I, item 3)

Name of Clinical Laboratory that offered the Training Program _____

Address of Clinical Laboratory _____

New York State Department of Health (DOH) Clinical Laboratory Permit Number _____

Name of Histocompatibility Training Program Director _____

Job Title _____

DOH Issued Clinical Laboratory Director Certificate of Qualification Category _____

During the entire time that Applicant was enrolled in the Training Program, were you the Clinical Laboratory Director, or Sole Assistant Clinical Laboratory Director of the Clinical Laboratory Identified above? ☐ Yes ☐ No

Do you currently serve as the Clinical Laboratory Director or Sole Assistant Clinical Laboratory Director of the Clinical Laboratory Identified above? ☐ Yes ☐ No

I hereby attest that the above-named applicant has completed a Training Program in Histocompatibility, which met all of the following criteria (check each):

☐ The Training Program covered clinical immunology, immunogenetics, basic molecular biology, and laboratory mathematics; general laboratory principles and skills, including infection control and aseptic technique; the practice of HLA typing and HLA antibody testing; specimen collection, processing and handling; instrumentation and equipment; reagent preparation and quality control; quality assurance, principles and techniques of histocompatibility assays, and crossmatching; antibody screening and identification; and determination of degree of HLA matching.

☐ The Training Program was at least 1750 hours (I year) and did not involve specimen testing or procedures that are outside the restricted license category of Histocompatibility.

☐ The Training Program provided continuous on-site personal supervision and training by qualified staff while the Applicant participated in the Training Program. Training Program staff met the following qualifications: (1) hold a DOH issued Laboratory Director Certificate of Qualification in Histocompatibility 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 histocompatibility testing and authorized by the Training Program Director to train or supervise the Applicant.

☐ I have verified that the applicant successfully completed the Histocompatibility Training Program.

☐ That the applicant started and completed the training program as follows:

Duration of Experience Starting Date ____ ____ ____ Completion Date ____ ____ ____
mo. day yr. mo. day yr.

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.

_____ _____
Training Program Director Signature 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.