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 Stem Cell Process

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 stem cell process 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

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
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 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 stem cell process which included:

Knowledge of:

☐ stem cell biology.

The program also included:

☐ 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.

as described in the previously submitted **Clinical Laboratory Technologist Restricted License In Stem Cell Process 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.