



**Section II: Certification of Education**

**Instructions to Registrar:**

1. Complete Part A or Part B to document the applicant's education.
2. Complete Part C (Certification) and return both pages of this form in an official school envelope with requested documents directly to the Office of the Professions at the address at the end of the form. Do not return this form to the applicant. This form will not be accepted if returned by the applicant.

Name of applicant: \_\_\_\_\_  
(Section I, item 5)

**Part A - Cytotechnology Program Registered by the New York State Education Department (NYSED) as licensure qualifying:** To be completed only by those schools whose cytotechnology program was, at the time the degree was (or will be) awarded, registered by the NYSED as licensure qualifying.

Completed the program on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ and was awarded the degree/advanced certificate of \_\_\_\_\_ on the date of \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Title of degree/advanced certificate) mo. day yr.

**OR**

on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ this institution determined that the above-named student met all requirements for the degree/advanced certificate and the institution has agreed to award the degree/advanced certificate of \_\_\_\_\_  
(Title of degree/advanced certificate)

**Part B - All Other Programs. An official transcript or marksheet giving courses completed by year and grades and a syllabus or description of the course of studies completed must be attached.**

1. Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school:  
Entrance date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Completion date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Withdrawal date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr. mo. day yr. mo. day yr.
2. Title of degree/advanced certificate awarded: \_\_\_\_\_
3. Date degree/advanced certificate awarded: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.  
Name of accrediting body or official organization that recognizes this program: \_\_\_\_\_  
Date of Accreditation: \_\_\_\_\_  
Year  
Address of accrediting body or official organization that recognizes this program: \_\_\_\_\_

**Part C - Certification**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Title or Official Position: \_\_\_\_\_

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

**(SEAL)**

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Cytotechnology Unit, 89 Washington Avenue, Albany, NY 12234-1000.**