

90



---

---

# Clinical Laboratory Technologist Restricted License Application Packet

---

---

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT

Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000

*Need Additional Information?*

Check our Web site for copies of forms, Education Law, approved programs and **More!**

**WWW.OP.NYSED.GOV**



December 2008

# THE UNIVERSITY OF THE STATE OF NEW YORK

## Regents of the University

MERRYL H. TISCH, Chancellor, B.A., M.A., Ed.D. ....	New York
MILTON L. COFIELD, Vice Chancellor, B.S., M.B.A., Ph.D. ....	Rochester
ROBERT M. BENNETT, Chancellor Emeritus, B.A., M.S. ....	Tonawanda
JAMES C. DAWSON, A.A., B.A., M.S., Ph.D. ....	Plattsburgh
ANTHONY S. BOTTAR, B.A., J.D. ....	Syracuse
GERALDINE D. CHAPEY, B.A., M.A., Ed.D. ....	Belle Harbor
HARRY PHILLIPS, 3rd, B.A., M.S.F.S. ....	Hartsdale
JAMES R. TALLON, JR., B.A., M.A. ....	Binghamton
ROGER TILLES, B.A., J.D. ....	Great Neck
CHARLES R. BENDIT, B.A. ....	Manhattan
BETTY A. ROSA, B.A., M.S. in Ed., M.S. in Ed., M.Ed., Ed.D. ....	Bronx
LESTER W. YOUNG, JR., B.S., M.S., Ed. D. ....	Oakland Gardens
CHRISTINE D. CEA, B.A., M.A., Ph.D. ....	Staten Island
WADE S. NORWOOD, B.A. ....	Rochester
JAMES O. JACKSON, B.S., M.A., PH.D. ....	Albany
KATHLEEN M. CASHIN, B.S., M.S., Ed.D. ....	Brooklyn
JAMES E. COTTRELL, B.S., M.D. ....	New York

### **Commissioner of Education**

#### **President of The University of the State of New York**

JOHN B. KING, JR.

### **Executive Deputy Commissioner**

VALERIE GREY

### **Associate Commissioner for the Professions**

DOUGLAS LENTIVECH

### **Acting Director of the Division of Professional Licensing Services**

SUSAN NACCARATO

### **Executive Secretary for the State Board for Clinical Laboratory Technology**

KATHLEEN M. DOYLE

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its educational programs, services and activities. Portions of this publication can be made available in a variety of formats, including braille, large print or audio tape, upon request. Inquiries concerning this policy of nondiscrimination should be directed to the Department's Office for Diversity, Ethics, and Access, Room 530, Education Building, Albany, NY 12234. Requests for additional copies of this publication may be made by contacting the Publications Sales Desk, Room 319, Education Building, Albany, NY 12234.

## Contents

Ways to Reach Us .....	ii
General Licensing Information .....	1
Applying for a Clinical Laboratory Technologist Restricted License .....	5
Completing the Application Forms .....	9
Applicant Checklist .....	11

## Forms

FORM 1	-	Application for A Restricted License
FORM 2	-	Certification of Professional Education
FORM 3	-	Verification of Other Professional Licensure/Certification (Not for New York City Certificate of Qualification)
FORM 4	-	Attestation of Training Program Content
FORM 4A	-	Certification of Completion of Training Program

## Additional Forms

FORM AD/NAME	-	Address/Name Change Form
--------------	---	--------------------------

### **FOR FUTURE REFERENCE**

**IN THE EVENT OF AN EMERGENCY** that impacts the licensed professions, the Office of the Professions will provide important information, specific to the situation, through our **Web site** ([www.op.nysed.gov](http://www.op.nysed.gov)), our **automated phone system** (518-474-3817), and/or our **regional offices**. This information will include emergency provisions for professional practice as well as updates on scheduled events and services (licensing examinations, professional discipline proceedings, examination reviews, etc.).

## Ways to reach us...



### ⇒ General Customer Service

The Office of the Professions has an automated customer service system that allows callers to **verify licenses, request information, and hear automated messages 24 hours a day.** The number is 518-474-3817, TDD/TTY 518-473-1426. Staff are available from 8:30 a.m. to 4:45 p.m., Eastern Time, Monday through Friday. You may also fax a message to 518-474-1449 or e-mail us at [op4info@mail.nysed.gov](mailto:op4info@mail.nysed.gov).

### ⇒ On The World Wide Web

Information about the Office of the Professions and the 48 licensed professions, including information on all licensees, is available on our home page at:

**[www.op.nysed.gov](http://www.op.nysed.gov)**

### ⇒ Certificate Application Status

Find out the **status of your license application** by checking our Web site where your name is added immediately when a license number is issued, or contact:

NYS Education Department, Office of the Professions, Division of Professional Licensing Services  
Clinical Laboratory Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000  
PHONE: 518-474-3817 ext. 592, FAX: 518-402-2323, E-MAIL: [opunit5@mail.nysed.gov](mailto:opunit5@mail.nysed.gov)  
Please include your name, social security number, date of birth, and the name of the profession.

### ⇒ Practice Issues

For answers to questions concerning practice issues, contact:

NYS Education Department, Office of the Professions, State Board for Clinical Laboratory Technology, 89 Washington Avenue, Albany, NY 12234-1000, PHONE: 518-474-3817 ext. 150, FAX: 518-486-4846, E-MAIL: [clinlabd@mail.nysed.gov](mailto:clinlabd@mail.nysed.gov)

# GENERAL LICENSING INFORMATION

Please read this general licensing information for all professions before proceeding to the detailed instructions for your profession.

---

## INTRODUCTION

A professional license is the authorization to practice and use a professional title in New York State. Your license is valid for life unless it is revoked, annulled, or suspended by the Board of Regents. This application packet contains the forms and instructions you need to apply for a license.

---

## LICENSURE AND REGISTRATION

Once received, your application and all required supporting material will be reviewed. If you meet all the licensure requirements, we will issue you a license and your first registration certificate. You will be entitled to practice in New York State as of the effective date of the license.

You may find out if your license has been issued (including your license number and effective date of licensure) by checking for your name in the listing of all licensed professionals on the Web at [www.op.nysed.gov](http://www.op.nysed.gov) or by calling our telephone verification service at 518-474-3817. Written confirmation of licensure -- your license parchment and registration certificate -- is mailed within two working days following the licensure date.

To practice in New York under the authority of your license, you must re-register every three years. You are automatically registered for your first registration period when your license is issued. Thereafter, we will send you a renewal application to the name and address we have on file (see the "Address or Name Changes" section on next page), at least four months before your registration expires.

---

## VERIFYING YOUR APPLICATION CREDENTIALS

To ensure authenticity of credentials, the New York State Education Department's Office of the Professions requires evidence of your compliance with each licensure requirement directly from the organization where you met the requirement (e.g., school, testing agency, licensing authority, director of a clinical laboratory, hospital, employer, etc.). These records and documents must bear an original (not photocopied) signature of the official who maintains the records and stamp or seal of the institution where the credentials are maintained. **You are responsible for asking organizations and individuals to complete and directly submit to us the documentation you need.** Keep a record of your verification requests. To ensure protection of the public, the Office of the Professions regularly re-verifies credentials directly with the issuing institution to assure authenticity. In some cases, this may delay licensure.

**NOTE: Forms and transcripts from the originating institution must be mailed directly to the Department from the issuing institution in a sealed official envelope bearing the institution's name and address. Verifying organizations may take eight weeks or more from the date of your request to send the required independent verifications. The Office of the Professions cannot evaluate your credentials until we receive the required documentation. You must consider this time factor in deciding when to submit your application for licensure.**

---

---

## ADDRESS OR NAME CHANGES

If your mailing address or name changes, you must contact the Department to update your records and provide the following identifying information: your full name, social security number, profession and date of birth. Failure to provide the Department with your change of address or name will delay processing your application.

**For address changes** you may phone, fax or e-mail:

Phone: 518-474-3817 ext. 592  
TDD/TTY 518-473-1426

Fax: 518-402-2323

E-mail: [opunit5@mail.nysed.gov](mailto:opunit5@mail.nysed.gov)

**For name changes** a fax or e-mail is not acceptable. You must provide written notification of any name change with an original notarized signature in your new name to:

NYS Education Department, Office of the Professions  
Division of Professional Licensing Services  
Clinical Laboratory Technology Unit  
89 Washington Avenue  
Albany, NY 12234-1000

**NOTE: Once you are licensed, Education Law requires that you notify the Department of any change in your mailing address or name within 30 days of that change. Failure to do so may be considered professional misconduct. It may also delay renewal and result in late fees to renew the registration of a professional license.** You may use the Form AD/NAME located in the back of this packet or print a copy from our Web site at [www.op.nysed.gov/anchange.pdf](http://www.op.nysed.gov/anchange.pdf) to notify the Department of a change in your address or name.

---

## PROFESSIONAL CONDUCT

All licensed practitioners must adhere to rules of professional conduct. The Education Law includes definitions of professional misconduct, and the Board of Regents has adopted Rules defining unprofessional conduct for all professions. Every licensee is also governed by a set of Laws, Rules, and Regulations for the practice of the profession.

Title 8 of the NYS Education Law is available on our Web site at [www.op.nysed.gov/title8.htm](http://www.op.nysed.gov/title8.htm)

Relevant sections of Part 29 of the Rules of the Board of Regents is available on our Web site at [www.op.nysed.gov/part29.htm](http://www.op.nysed.gov/part29.htm).

---

---

**RECORDS RETENTION AND DISPOSITION STATEMENT**

Applications are considered active while an applicant is providing documentation to meet the requirements for a professional license or post-licensure certificate (i.e., examination grades, educational credentials and professional work experience).

If you withdraw your application or your application is inactive for five (5) consecutive years, any documents submitted as part of your application will be destroyed in accordance with the Records Retention and Disposition schedule on file with the State Archives and Records Administration.

---

**DISCLOSURE OF SOCIAL SECURITY NUMBERS**

In accordance with Federal and State laws, the New York State Education Department requires that all applicants for professional licensure provide their Federal Social Security Number (SSN). Individuals without a SSN will be assigned a random, computer-generated nine-digit identifier. The agency will use the SSN or assigned numeric identifier to maintain accurate license and registration records. This information may be shared with other State or Federal agencies, consistent with applicable laws and departmental policy, but will otherwise be kept confidential.

The specific statutory authority for requiring Federal Social Security Numbers is in the following: Federal Law-Privacy Act of 1974 (Section 7 of P.L., 93-579); Welfare Reform Act of 1996 (42 USCA 666 (a)); New York State Law-Title 8, Section 6507, paragraph 4(e) Education Law; Section 5 of the Tax Law.

For additional information see: [www.oft.state.ny.us/arcpolicy/policy/tp\\_974.htm](http://www.oft.state.ny.us/arcpolicy/policy/tp_974.htm)

---



# APPLYING FOR A CLINICAL LABORATORY TECHNOLOGIST RESTRICTED LICENSE

---

## GENERAL REQUIREMENTS

Practice as a clinical laboratory technologist within the areas of Cytogenetics; Flow Cytometry/Cellular Immunology; Histocompatibility; Molecular Diagnosis to the Extent Such Molecular Diagnosis Is Included In Genetic Testing-Molecular and Molecular Oncology; Molecular Diagnosis Including But Not Limited to Genetic Testing-Molecular and Molecular Oncology for Employment in Cancer Centers and Designated Training Hospitals; and Stem Cell Process in New York State requires a license as a clinical laboratory technologist or a restricted license as a clinical laboratory technologist, unless otherwise exempt under the law.

**To receive a clinical laboratory technologist restricted license to practice in one of the previously mentioned areas in New York State you must:**

- be of good moral character;
- be at least 18 years of age;
- meet education requirements; and
- meet experience requirements.

You must file an Application for a Restricted License (Form 1) and the other forms indicated, along with the appropriate fee, to the Office of the Professions at the address specified on each form. **It is your responsibility to follow up with anyone you have asked to send us material.**

The specific requirements for licensure are contained in Title 8, Article 165 of New York's Education Law and Subpart 79-13 of the Regulations of the Commissioner of Education. The Law and Regulations are available on our Web site at [www.op.nysed.gov/clp.htm](http://www.op.nysed.gov/clp.htm).

---

## FEES (fees listed are those in effect at the time this application was printed)

The fee for a clinical laboratory technologist restricted license and first registration is \$371.

Fees are subject to change. The fee due is the one in law when your application is received (unless fees are increased retroactively). You will be billed for the difference if fees have been increased.

- Do not send cash.
- Make your personal check or money order payable to the New York State Education Department. **Your cancelled check is your receipt.**
- Mail your application and fee to: **NYS Education Department, Office of the Professions at the address at the end of the Application for a Restricted License (Form 1).**

**PLEASE NOTE:** Payment submitted from outside the United States should be made by check or draft on a United States bank and in United States currency; payments submitted in any other form will not be accepted and will be returned.

---

## PARTIAL REFUNDS

Individuals who withdraw their licensure application may be entitled to a partial refund.

- For the procedure to withdraw your application, contact the Clinical Laboratory Technology Unit by e-mailing [opunit5@mail.nysed.gov](mailto:opunit5@mail.nysed.gov) or by calling 518-474-3817 ext. 592 or by faxing 518-402-2323.
- The State Education Department is not responsible for any fees paid to an outside testing or credentials verification agency.

If you withdraw your application, obtain a refund, and then decide to seek New York State licensure at a later date, you will be considered a new applicant, and you will be required to pay the licensure and registration fees and meet the licensure requirements in place at the time you reapply.

---

## EDUCATION REQUIREMENTS

To meet the professional education requirements for a clinical laboratory technologist restricted license, you must present evidence of completion of a baccalaureate or higher degree program in the major of biology, chemistry, the physical sciences, or mathematics from a program registered by the State Education Department or determined by the Department to be the substantial equivalent.

In addition to the degree requirement, you must complete an approved training program in the specific area in which you are seeking a restricted license. The content of the training program shall be described and attested to by the clinical director of the laboratory in which the program is located prior to the beginning of the your program\* using the respective Form 4.

**Note:** \*You may not begin a program until the application has been approved and a certificate has been issued.

The training program shall consist of not less than one year of full-time training in the specific area in which you are seeking certification, which shall consist of no less than 1750 hours in a calendar year, in the specific area in which you are seeking certification, or the part-time equivalent thereof, as determined by the department.

The respective areas for each field are:

### **Cytogenetics**

A program in cytogenetics must contain knowledge of:

- chromosome structure/behavior and its correlation with phenotype and of chromosomal abnormalities.

The program shall also include but need not be limited to:

- general laboratory principles and skills;
- including infection control and aseptic technique; quality control and quality assurance;
- clinical cytogenetics;
- general knowledge of human genetics;
- laboratory mathematics;
- the collection, handling, preparation and processing of pertinent specimens;
- the use of appropriate cell culture techniques;
- the principles and techniques for harvesting specimens or cell cultures; and,
- the principles and techniques of chromosome banding, staining, analysis, and instrumentation

### **Flow Cytometry/Cellular Immunology**

A program in flow cytometry/cellular immunology must contain knowledge of:

- The technique for counting, sorting, and characterization of cells suspended in a fluid stream based on their physical properties and expression of cell surface molecules;

The program shall also include but need not be limited to:

- general laboratory principles and skills;
- infection control and aseptic technique;
- quality control and quality assurance;
- instrumentation and equipment;
- the basic principles of flow cytometry, including specimen preparation, fluidics and electronics;
- fluorochrome selection;
- antibody selection;
- the design of flow cytometry procedures, including routine standardization and quality management; and
- specific clinical applications.

## **Histocompatibility**

A program in histocompatibility must contain knowledge of:

- clinical immunology;
- immunogenetics;
- basic molecular biology; and
- and laboratory mathematics.

The program shall also include but need not be limited to:

- 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.

## **Molecular Diagnosis Restricted to Molecular Diagnosis Included In Genetic Testing-Molecular and Molecular Oncology**

A program in molecular diagnosis must contain knowledge of:

- the role of molecular genetics in tumor diagnosis and individualized tumor therapies that are being defined and implemented.

The program shall also include but need not be limited to:

- general laboratory principles;
- infection control and aseptic technique;
- quality control and quality assurance;
- applicable laboratory skills;
- general principles of molecular biology, clinical molecular genetics and molecular diagnosis;
- laboratory mathematics;
- basic principles of nucleic acid extraction, modification, amplification, identification, and unidirectional workflow techniques to avoid cross contamination;
- electrophoresis and other separation techniques;
- transfer and hybridization techniques and specific techniques of nucleic acid amplification and identification.

## **Molecular Diagnosis Not Restricted to Molecular Diagnosis Included in Genetic Testing-Molecular and Molecular Oncology for Employment in Cancer Centers and Designated Training Hospitals**

A program in molecular diagnosis must contain knowledge of:

- the role of molecular genetics in tumor diagnosis and individualized tumor therapies that are being defined and implemented.

The program shall also include but need not be limited to:

- general laboratory principles;
- infection control and aseptic technique;
- quality control and quality assurance;
- applicable laboratory skills;
- general principles of molecular biology, clinical molecular genetics and molecular diagnosis;
- laboratory mathematics;
- basic principles of nucleic acid extraction, modification, amplification, identification, and unidirectional workflow techniques to avoid cross contamination;

- electrophoresis and other separation techniques;
- transfer and hybridization techniques and specific techniques of nucleic acid amplification and identification; and
- additional training in molecular diagnosis acceptable to the Department that would enable you to practice competently.

### **Stem Cell Process**

A program in stem cell process must contain knowledge of:

- stem cell biology

The program shall also include but need not be limited to:

- 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.

The Department must receive, directly from the clinical laboratory director of the program, verification of completion of an approved training program using the respective Form 4A.

---

## **ADDITIONAL EDUCATIONAL REQUIREMENTS**

Applicants must be familiar with the following general rules and regulations of any clinical laboratory, as well as rules and standards of specific relevance to areas of testing and reporting in which they are or expect to be engaged.

### **New York State Public Health Law and Regulations**

The laws, rules and regulations listed below can be accessed on the Web at [www.wadsworth.org/labcert/regaffairs/RAindex.htm](http://www.wadsworth.org/labcert/regaffairs/RAindex.htm).

- Article V, Title V Clinical Laboratory and Blood Banking Services
- Article 31 Human Blood and Transfusion Services
- Article 27F HIV and AIDS Related Information
- Article 43-B, Organ, Tissue, and Body Parts
- Article V, Title VI Laboratory Business Practices
- Section 79.1 of the New York State Civil Rights Law, Confidentiality of Genetic Testing
- Part 19 of 10 (NYCRR) Clinical Laboratory Directors
- Subpart 34-2 of 10 (NYCRR) Laboratory Business Practices
- Subpart 58-1 of 10 (NYCRR) Clinical Laboratories
- Subpart 58-2 of 10 (NYCRR) Blood Banking
- Subpart 58-5 of 10 (NYCRR) Hematopoietic Progenitor Cell Banks
- Subpart 58-8 of 10 (NYCRR) Human Immunodeficiency Virus (HIV) Testing
- Subpart 63 of 10 (NYCRR) AIDS/HIV Testing, Reporting and Confidentiality

### **Federal Laws and Regulations**

The laws and regulations listed below can be accessed on the Web at [www.cms.hhs.gov/clia/](http://www.cms.hhs.gov/clia/).

- Current CLIA Regulations
- Part 493 Laboratory Requirements

# COMPLETING THE APPLICATION FORMS

## *for a Clinical Laboratory Technologist Restricted License*

---

### INSTRUCTIONS

Please type or print all information and sign all forms in black or blue ink. Original signatures are required on all forms.

---

### FORM 1 - APPLICATION FOR A RESTRICTED LICENSE

**All applicants for a certificate** must complete this form and submit it with the \$371 fee for licensure and first registration directly to the Office of the Professions at the address at the end of Form 1. Make checks payable to the New York State Education Department. **NOTE: Your cancelled check is your receipt.**

You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. **Your signature on Form 1 must be notarized by a Notary Public.**

---

### FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION

**This form must be submitted directly to the Office of the Professions by the professional school you attended. This form will not be accepted if submitted by the applicant or any party other than the school official.**

Section I: Complete this section of the form before sending the entire form to your school. Be sure to sign and date item 11.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

---

### FORM 3 - VERIFICATION OF OTHER PROFESSIONAL LICENSURE/CERTIFICATION

**Complete this form if you hold, or have ever held, a license or certificate to practice any profession\* in any jurisdiction.**

**This form must be submitted directly by the licensing/certifying authority. The Office of the Professions will not accept this form if submitted by the applicant. This does not apply to certification issued by private membership organizations (i.e., ASCP).**

Section I: Complete this section before sending the entire form to the licensing/certifying authority of each jurisdiction in which you are or have been licensed/certified. Be sure to sign and date item 8.

Section II: The licensing/certifying authority must complete this section, sign, date and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

Note: A Form 3 is not required for licenses/certificates issued by the New York State Education Department.

\*Profession is defined as professional titles licensed under New York State Education Law. (See page 2 of the Address/Name Change Form at the end of this packet for a list of those titles.)

**Please note:** This form is to verify other professional licensure only and should **NOT** be used to verify New York City Certification of Qualification or any affiliations with professional associations or organizations.

---

**FORM 4 - ATTESTATION OF TRAINING PROGRAM CONTENT**

**Note: Form 4 is required to obtain a certificate to participate in particular training program you may not begin a program until the application has been approved and a certificate has been issued.**

**This form must be submitted directly by the Clinical Laboratory Director of the training program in which you wish to participate. The Office of the Professions will not accept this form if submitted by the applicant.**

Section I: Complete this section of the form.

Section II: Review and complete Section II with the Clinical Laboratory Director of the training program in which you wish to participate. Then ask the Clinical Laboratory Director to return the entire form to the Office of the Professions at the address at the end of the form. Be sure that both you and the Clinical Laboratory Director sign and date the attestations.

---

**FORM 4A - CERTIFICATION OF COMPLETION OF TRAINING PROGRAM**

**This form must be submitted directly by the Clinical Laboratory Director of the training program that you completed. The Office of the Professions will not accept this form if submitted by the applicant.**

Section I: Complete this section of the form before sending the entire form the Clinical Laboratory Director of the training program you completed. Be sure to sign and date item 7.

Section II: The Clinical Laboratory Director must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

---

---

**Completing Additional Forms**

---

---

**FORM AD/NAME - ADDRESS/NAME CHANGE FORM**

You are required to notify us within 30 days of any name or address changes. Please read the instructions and complete the appropriate sections of this form.

**CLINICAL LABORATORY TECHNOLOGIST**  
**RESTRICTED LICENSE**

**APPLICANT CHECKLIST**

*Please complete and keep this checklist as a reminder of what forms you have filed and when you filed them. This is for your reference and should not be submitted with your application forms. **You should keep a copy of all application forms submitted.***

**CHECK (✓) AND DATE EACH STEP WHEN COMPLETED.**

\_\_\_\_\_ 1. Have you completed and sent the following to the Office of the Professions?

\_\_\_\_\_ A. FORM 1 - APPLICATION FOR A RESTRICTED LICENSE

\_\_\_\_\_ B. FEE (\$371) - FOR A CERTIFICATE AND INITIAL REGISTRATION

\_\_\_\_\_ 2. Have you completed and forwarded the following forms to the appropriate institution(s) or agencies? Keep copies of the requests so that you may check with them to be sure they have submitted the information.

\_\_\_\_\_ A. FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION

Sent to the following educational institutions:

Date sent

_____	_____
_____	_____
_____	_____

\_\_\_\_\_ B. FORM 3 - VERIFICATION OF OTHER PROFESSIONAL LICENSURE/CERTIFICATION - All applicants licensed in another jurisdiction must complete and forward this form to the appropriate licensing authority for submission to the Department.

Sent to the following national certifying organization:

Date sent

_____	_____
_____	_____

\_\_\_\_\_ C. FORM 4 - ATTESTATION OF TRAINING PROGRAM CONTENT

Sent to the following Clinical Laboratory Director:

Date sent

_____	_____
-------	-------

\_\_\_\_\_ D. FORM 4A - CERTIFICATION OF COMPLETION OF TRAINING PROGRAM

Sent to the following Clinical Laboratory Director:

Date sent

_____	_____
-------	-------

**TO SPEED PROCESSING OF YOUR APPLICATION:**

- **Submit your application for a New York State certificate in plenty of time to allow verifying organizations to send the required independent verifications to the Office of the Professions. This may take eight weeks or more.**
- Notify the Office of the Professions promptly of any address or name changes.
- Respond promptly to requests for additional information from the Office of the Professions.

# Clinical Laboratory Technologist Restricted License Form 1

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

## Department Use Only

## Application for a Restricted License

Applicants Must Complete All Pages Of This Application ***In Ink***

All applicants for licensure must complete this form and submit it with the \$371 fee for licensure and first registration directly to the Office of the Professions at the address at the end of this form. You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Form 1 must be notarized by a Notary Public.

90	\$371	ER
----	-------	----

**1 Check what restricted license you are applying for:**

- Cytogenetics
- Flow Cytometry/Cellular Immunology
- Histocompatibility
- Molecular Diagnosis (Restricted)
- Molecular Diagnosis for Employment in Cancer Centers (Not Restricted)
- Stem Cell Process

**2 Social Security Number**

(Leave this blank if you do not have a U.S. Social Security Number)

**3 Birth Date** Month   Day   Year

**4 Print Name Exactly As You Wish It To Appear On Your License**

Last

First

Middle

**5 Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State   Zip Code

Country/  
Province

**NYS License Number**

**Date Issued**

**Initials**

**6 Telephone/E-Mail Address**

Daytime phone

Area Code Phone

**E-mail Address** (please print clearly)

**7 New York State DMV ID Number**  
(Driver or Non-Driver ID)

**8 Name as it appears on degree or other credentials (if different from above):** \_\_\_\_\_

**9 Have you previously applied for New York State licensure in any profession?**  Yes  No

If "yes", in what profession(s)? \_\_\_\_\_

**10 Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?**  Yes  No

**11 Are criminal charges pending against you in any court?**  Yes  No

**12 Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?**  Yes  No

**13 Are charges pending against you in any jurisdiction for any sort of professional misconduct?**  Yes  No

**14 Has any hospital or licensed facility or clinical laboratory restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?**  Yes  No

**NOTE:** If you answer "Yes" to any questions numbered 10-14, submit a letter giving a complete detailed explanation. Include copies of any court records (conviction records), and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

**15** Please print clearly giving an accurate record of your educational preparation below. YOU MUST COMPLETE ALL INFORMATION FOR ALL SCHOOLS/COLLEGES/UNIVERSITIES ATTENDED AND DIPLOMAS AND/OR DEGREES RECEIVED OR YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE. Attach additional sheets if necessary.

**Name of High School/Secondary School or GED Diploma issuer:** \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Number of years attended: \_\_\_\_\_ Attendance from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo. day yr. mo. day yr.

Graduation date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ or Date GED issued: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo. day yr. mo. day yr.

**Undergraduate College Study**

Name of School: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Major/Concentration: \_\_\_\_\_

Number of years attended: \_\_\_\_\_ Attendance from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo. day yr. mo. day yr.

Title of degree (in the original language): \_\_\_\_\_

Date degree awarded: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo. day yr.

**Graduate Study**

Name of School: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Major/Concentration: \_\_\_\_\_

Number of years attended: \_\_\_\_\_ Attendance from: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo. day yr. mo. day yr.

Title of degree (in the original language): \_\_\_\_\_

Date degree awarded: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 mo. day yr.

**16** Do you now hold, or have you ever held, a license or certificate to practice any profession in any jurisdiction?  Yes  No

If yes, list each license/certificate, state or jurisdiction and provide appropriate information in the columns below. **A Form 3 must be submitted for each license/certificate listed unless it is a license/certificate issued by the New York State Education Department. See the Applicant Instructions on Form 3 for specific information about completing and submitting the form.**

\*Profession is defined as professional titles licensed under New York State Education Law.

Professional Title	State or Jurisdiction	Date License/Certificate Issued	License/Certificate Number	Limitations On License/Certificate

**17 Student Loan Disclosure**

The State Education Department is required\* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. Your license application is not complete without this information.

- A) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation?  Yes  No
- B) If you have such a loan(s), is any part in default?  Yes  No

\*New York State Education Law, Section 6501-a

**18 Child Support Obligation**

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support\*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

- A.  I am not under an obligation to pay child support  
OR
- B.  I am under an obligation to pay child support and (please check only one of the following)
  - I am current and am not four months or more in arrears in the payment of child support; or,
  - I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
  - The child support obligation is the subject of a pending court proceeding; or,
  - I am receiving public assistance or supplemental security income; or,
  - None of the above four statements apply.

\* New York State General Obligations Law, section 3-503.

**19 Citizenship/Immigration Status:**

Federal Law limits the issuance of professional licenses, registrations and limited permits to United States citizens or qualified aliens. To comply with this Federal law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am:

- A. A United States citizen or National.
- B. An alien lawfully admitted for permanent residence in the United States.
- C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.
- D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.
- E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year.
- F. An alien whose deportation is being withheld under Section 241 (b)(3) of the Immigration and Nationality Act.
- G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.
- H. Non Immigrant (Temporarily in U.S.)  
Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: \_\_\_\_\_
- I. I do not reside in the United States.

If you checked any of the boxes from B-H, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): \_\_\_\_\_

USCIS number

**QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.**

**20 Gender And Ethnicity: (This item is optional.)**

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

- Gender:  Male  Female
- Ethnicity:  White (not Hispanic)  Black (not Hispanic)  Asian  Hispanic  Native American

**21** I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying the Division of Professional Licensing Services in writing.

Yes

No

Please initial: \_\_\_\_\_

**22 Affidavit With Acknowledgment (Notarization required.)**

**Applicant**

I 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.

**In addition**, if I am applying for licensure under grandparenting, I certify that I believe in good faith that I currently meet or will meet the requirements for licensure by the specified completion dates.

I am also certifying that 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 that are identified in the **Additional Educational Requirements** section in either the paper Application Packet or under License Requirements on the Office of the Professions' Web site at [www.op.nysed/clp.htm](http://www.op.nysed/clp.htm). (This certification does not apply to those applying for licensure as a clinical laboratory technologist under Methods 1, 4 or 5 or for licensure as a certified clinical laboratory technician under Methods 1 or 3.)

Signature of the applicant: \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Notary**

State of \_\_\_\_\_ County of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature \_\_\_\_\_

Notary ID number \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.



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

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

**OR**

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

**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: \_\_\_\_\_
3. Date degree: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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, Clinical Laboratory Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000.**



**Section II: Verification of Licensure/Certification: (Please print or type)**

**Instructions to the Licensing/Certifying Authority:** Please complete items 1-4, sign and date the certification and return both pages of this form in an official envelope directly to the Office of the Professions at the address below. This form will not be accepted if returned by the applicant. Attach additional sheets if necessary.

**1** Name of applicant: \_\_\_\_\_  
(Section I, item 6)

**2** Professional title on license/certificate: \_\_\_\_\_  
License/certificate number: \_\_\_\_\_ Date of licensure/certification: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**3** Verification of licensure/certification  
What requirements did the applicant meet to become licensed/certified in your jurisdiction?  
Education: Degree: \_\_\_\_\_  
Examination: Title: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Score: \_\_\_\_\_  
mo. day yr.  
Experience:  None  \_\_\_\_\_ hours Describe (i.e., clock hours) \_\_\_\_\_  
 Endorsement of license from or reciprocity with \_\_\_\_\_  
(name of jurisdiction)  
 Grandparented

**4** A. Has the applicant identified in Section I been subject to any disciplinary action?  Yes  No  
B. Are any charges pending against this individual?  Yes  No  
**If the answer to either of these questions is "yes," please attach a complete explanation with any supporting documentation.**

**Certification**

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted in item 4 above or in any attachments, this licensing/certifying authority has never taken any disciplinary action against this person and that in so far as the licensing/certifying authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.  
Print name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Licensing/certifying authority: \_\_\_\_\_ **(SEAL)**  
Address: \_\_\_\_\_  
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, Clinical Laboratory Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000.**



**Section II: Program Information (continued)**

Both the applicant and Clinical Laboratory Director must initial each listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	<b>Applicant (Initial)</b>	<b>Clinical Laboratory Director (Initial)</b>
<b>The training program shall include knowledge of:</b>		
• chromosome structure/behavior and its correlation with phenotype and of chromosomal abnormalities.	_____	_____
<b>The program shall also include, but need not be limited to:</b>		
• general laboratory principles and skills;	_____	_____
• including infection control and aseptic technique; quality control and quality assurance;	_____	_____
• clinical cytogenetics;	_____	_____
• general knowledge of human genetics;	_____	_____
• laboratory mathematics;	_____	_____
• the collection, handling, preparation and processing of pertinent specimens;	_____	_____
• the use of appropriate cell culture techniques;	_____	_____
• the principles and techniques for harvesting specimens or cell cultures; and,	_____	_____
• the principles and techniques of chromosome banding, staining, analysis, and instrumentation	_____	_____

**Description of Program:** Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

---

---

---

---

**Applicant Attestation (This form must bear an original signature)**

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

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

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

**Clinical Laboratory Director Attestation (This form must bear an original signature)**

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

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

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.**



**Section II: Certification of Completion**

**Instructions to Clinical Laboratory Director:** Complete this Section, sign and date the affirmation and send both pages of this form directly to the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Name of applicant: \_\_\_\_\_  
(Section I, item 3)

I am attesting that the applicant named above has completed a training program for cytogenetics which included:

**Knowledge of:**

- chromosome structure/behavior and its correlation with phenotype and of chromosomal abnormalities.

**The program also included:**

- general laboratory principles and skills;
- including infection control and aseptic technique; quality control and quality assurance;
- clinical cytogenetics;
- general knowledge of human genetics;
- laboratory mathematics;
- the collection, handling, preparation and processing of pertinent specimens;
- the use of appropriate cell culture techniques;
- the principles and techniques for harvesting specimens or cell cultures; and,
- the principles and techniques of chromosome banding, staining, analysis, and instrumentation

as described in the previously submitted **Clinical Laboratory Technologist Restricted License in Cytogenetics 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.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Laboratory Director Affirmation (This form must bear an original signature)**

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

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**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.**



**Section II: Program Information (continued)**

Both the applicant and Clinical Laboratory Director must initial each listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	<b>Applicant (Initial)</b>	<b>Clinical Laboratory Director (Initial)</b>
<b>The training program shall include knowledge of:</b>		
• The technique for counting, sorting, and characterization of cells suspended in a fluid stream based on their physical properties and expression of cell surface molecules;	_____	_____
<b>The program shall also include, but need not be limited to:</b>		
• general laboratory principles and skills;	_____	_____
• infection control and aseptic technique;	_____	_____
• quality control and quality assurance;	_____	_____
• instrumentation and equipment;	_____	_____
• the basic principles of flow cytometry, including specimen preparation, fluidics and electronics;	_____	_____
• fluorochrome selection;	_____	_____
• antibody selection;	_____	_____
• the design of flow cytometry procedures, including routine standardization and quality management; and	_____	_____
• specific clinical applications.	_____	_____

**Description of Program:** Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Applicant Attestation (This form must bear an original signature)**

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

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

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

**Clinical Laboratory Director Attestation (This form must bear an original signature)**

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

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

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.**



**Section II: Certification of Completion**

**Instructions to Clinical Laboratory Director:** Complete this Section, sign and date the affirmation and send both pages of this form directly to the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Name of applicant: \_\_\_\_\_  
(Section I, item 3)

I am attesting that the applicant named above has completed a training program for flow cytometry/cellular immunology which included:

**Knowledge of:**

- The technique for counting, sorting, and characterization of cells suspended in a fluid stream based on their physical properties and expression of cell surface molecules;

**The program also included:**

- general laboratory principles and skills;
- infection control and aseptic technique;
- quality control and quality assurance;
- instrumentation and equipment;
- the basic principles of flow cytometry, including specimen preparation, fluidics and electronics;
- fluorochrome selection;
- antibody selection;
- the design of flow cytometry procedures, including routine standardization and quality management; and
- specific clinical applications.

as described in the previously submitted **Clinical Laboratory Technologist Restricted License in Flow Cytometry/Cellular Immunology 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.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Laboratory Director Affirmation (This form must bear an original signature)**

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

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**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.**



**Section II: Program Information (continued)**

Both the applicant and Clinical Laboratory Director must initial each listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	<b>Applicant (Initial)</b>	<b>Clinical Laboratory Director (Initial)</b>
<b>The training program shall include knowledge of:</b>		
• clinical immunology;	_____	_____
• immunogenetics;	_____	_____
• basic molecular biology; and	_____	_____
• and laboratory mathematics.	_____	_____

**The program shall also include, but need not be limited to:**

• 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.	_____	_____

**Description of Program:** Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Applicant Attestation (This form must bear an original signature)**

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

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

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

**Clinical Laboratory Director Attestation (This form must bear an original signature)**

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

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

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.**



**Section II: Certification of Completion**

**Instructions to Clinical Laboratory Director:** Complete this Section, sign and date the affirmation and send both pages of this form directly to the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Name of applicant: \_\_\_\_\_  
(Section I, item 3)

I am attesting that the applicant named above has completed a training program for Histocompatibility which included:

**Knowledge of:**

- clinical immunology;
- immunogenetics;
- basic molecular biology; and
- and laboratory mathematics.

**The program also included:**

- 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.

as described in the previously submitted **Clinical Laboratory Technologist Restricted License in Histocompatibility 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.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Laboratory Director Affirmation (This form must bear an original signature)**

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

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**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.**



**Section II: Program Information (continued)**

Both the applicant and Clinical Laboratory Director must initial each listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	<b>Applicant (Initial)</b>	<b>Clinical Laboratory Director (Initial)</b>
<b>The training program shall include knowledge of:</b>		
• the role of molecular genetics in tumor diagnosis and individualized tumor therapies that are being defined and implemented.	_____	_____
<b>The program shall also include, but need not be limited to:</b>		
• general laboratory principles;	_____	_____
• infection control and aseptic technique;	_____	_____
• quality control and quality assurance;	_____	_____
• applicable laboratory skills;	_____	_____
• general principles of molecular biology, clinical molecular genetics and molecular diagnosis;	_____	_____
• laboratory mathematics;	_____	_____
• basic principles of nucleic acid extraction, modification, amplification, identification, and unidirectional workflow techniques to avoid cross contamination;	_____	_____
• electrophoresis and other separation techniques;	_____	_____
• transfer and hybridization techniques and specific techniques of nucleic acid amplification and identification.	_____	_____

**Description of Program:** Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Applicant Attestation (This form must bear an original signature)**

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

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

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

**Clinical Laboratory Director Attestation (This form must bear an original signature)**

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

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

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.**



**Section II: Certification of Completion**

**Instructions to Clinical Laboratory Director:** Complete this Section, sign and date the affirmation and send both pages of this form directly to the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Name of applicant: \_\_\_\_\_  
(Section I, item 3)

I am attesting that the applicant named above has completed a training program for molecular diagnosis which included:

**Knowledge of:**

- the role of molecular genetics in tumor diagnosis and individualized tumor therapies that are being defined and implemented.

**The program also included:**

- general laboratory principles;
- infection control and aseptic technique;
- quality control and quality assurance;
- applicable laboratory skills;
- general principles of molecular biology, clinical molecular genetics and molecular diagnosis;
- laboratory mathematics;
- basic principles of nucleic acid extraction, modification, amplification, identification, and unidirectional workflow techniques to avoid cross contamination;
- electrophoresis and other separation techniques;
- transfer and hybridization techniques and specific techniques of nucleic acid amplification and identification.

as described in the previously submitted **Clinical Laboratory Technologist Restricted License in Molecular Diagnosis 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.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Laboratory Director Affirmation (This form must bear an original signature)**

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

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**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.**



**Section II: Program Information (continued)**

Both the applicant and Clinical Laboratory Director must initial each listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	<b>Applicant (Initial)</b>	<b>Clinical Laboratory Director (Initial)</b>
<b>The training program shall include knowledge of:</b>		
• the role of molecular genetics in tumor diagnosis and individualized tumor therapies that are being defined and implemented.	_____	_____
<b>The program shall also include, but need not be limited to:</b>		
• general laboratory principles;	_____	_____
• infection control and aseptic technique;	_____	_____
• quality control and quality assurance;	_____	_____
• applicable laboratory skills;	_____	_____
• general principles of molecular biology;	_____	_____
• clinical molecular genetics and molecular diagnosis;	_____	_____
• laboratory mathematics;	_____	_____
• basic principles of nucleic acid extraction, modification, amplification, identification, and unidirectional workflow techniques to avoid cross contamination;	_____	_____
• electrophoresis and other separation techniques;	_____	_____
• transfer and hybridization techniques and specific techniques of nucleic acid amplification and identification.	_____	_____
• have completed additional training in molecular diagnosis acceptable to the Department that would enable the applicant to practice competently.*	_____	_____

\*Applicants seeking this certificate must provide documentation demonstrating additional training in molecular diagnosis to the Department for review and approval. Guidance will be provided on the Clinical Laboratory Web site at [www.op.nysed.gov/clt.htm](http://www.op.nysed.gov/clt.htm).

**Description of Program:** Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant Attestation (This form must bear an original signature)**

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

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

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

**Clinical Laboratory Director Attestation (This form must bear an original signature)**

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

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

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.**



**Section II: Certification of Completion**

**Instructions to Clinical Laboratory Director:** Complete this Section, sign and date the affirmation and send both pages of this form directly to the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Name of applicant: \_\_\_\_\_  
(Section I, item 3)

I am attesting that the applicant named above has completed a training program for molecular diagnosis which included:

**Knowledge of:**

- the role of molecular genetics in tumor diagnosis and individualized tumor therapies that are being defined and implemented.

**The program also included:**

- general laboratory principles;
- infection control and aseptic technique;
- quality control and quality assurance;
- applicable laboratory skills;
- general principles of molecular biology;
- clinical molecular genetics and molecular diagnosis;
- laboratory mathematics;
- basic principles of nucleic acid extraction, modification, amplification, identification, and unidirectional workflow techniques to avoid cross contamination;
- electrophoresis and other separation techniques;
- transfer and hybridization techniques and specific techniques of nucleic acid amplification and identification; and
- additional training in molecular diagnosis acceptable to the Department that would enable the applicant to practice competently.

as described in the previously submitted **Clinical Laboratory Technologist Restricted License in Molecular Diagnosis for Employment in Cancer Centers and Designated Training Hospitals 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.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Laboratory Director Affirmation (This form must bear an original signature)**

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

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**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.**



**Section II: Program Information (continued)**

Both the applicant and Clinical Laboratory Director must initial each listed below to show they agree that the following content will be included within the 1750 clock hours (one year) training program.

	<b>Applicant (Initial)</b>	<b>Clinical Laboratory Director (Initial)</b>
<b>The training program shall include knowledge of:</b>		
• stem cell biology	_____	_____
<b>The program shall also include, but need not be limited to:</b>		
• 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.	_____	_____

**Description of Program:** Provide a general description of the structure and sequence of the training program, including the distribution of time, e.g. full-time, part-time, and the plan for supervision, including the positions of any persons involved in supervision. Provide trainee's designated title, such as intern, trainee, fellow or student.

---

---

---

---

---

---

**Applicant Attestation (This form must bear an original signature)**

I hereby attest that I understand the above listed content must be included within the 1750 clock hour (one year) training program I wish to participate in.

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

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

**Clinical Laboratory Director Attestation (This form must bear an original signature)**

I hereby attest that I agree that the above listed content will be included within the 1750 clock hour (one year) training program.

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

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.**



**Section II: Certification of Completion**

**Instructions to Clinical Laboratory Director:** Complete this Section, sign and date the affirmation and send both pages of this form directly to the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Name of applicant: \_\_\_\_\_  
(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.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Laboratory Director Affirmation (This form must bear an original signature)**

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

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**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.**

**ADDRESS/NAME CHANGE FORM**

**INSTRUCTIONS**

Use this form to report a change in your address and/or name. Please read these instructions carefully and be sure you complete the appropriate sections of this form. Please print clearly in ink.

- **For address changes only:** Complete Sections I, II, and IV. **For address changes only**, you may fax this form to the Records and Archives Unit at 518-486-3617 or provide the required information by E-mail: oparchiv@mail.nysed.gov. Your records will be updated. Currently registered licensed professionals will be sent a new registration certificate.
- **For name changes only:** Complete Sections I, III, IV and V. **Name changes** require an original notarized signature in your new name and cannot be accepted prior to your official change of name. Sign the Section IV affidavit and have your signature notarized by a notary public. Currently registered licensed professionals will be sent a new registration certificate.
- **For address and name changes:** Complete all sections.

Licensed professionals can check the Office of the Professions' Web site at www.op.nysed.gov to verify your name, city, state, registration expiration date, and license number on record.

**NOTE:** Important information and registration renewals will be sent to the address on file for you. **You must notify the Department in writing within 30 days if your address or name changes.**

**Section I: Your General Information**

1. Name (currently on record): \_\_\_\_\_

2. Social Security Number:          Birth Date: Month   Day   Year

Telephone: Home: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

3. Are you reporting an address and/or name change?  address change  name change  both

4. Effective date of change: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **(Note: Changes cannot be accepted until after the effective date.)**

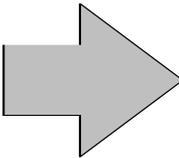
5. Licensure status in New York State:

I am an applicant for licensure in New York State for the licensed profession(s) of: \_\_\_\_\_

I am currently licensed in New York State in the profession(s) of: \_\_\_\_\_ (see list of professions on page 2)

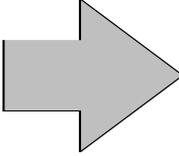
\_\_\_\_\_ New York State license number:

**Section II: Address Change (please print)**

Information <u>C</u> urrently On Record		New Information
Apt./Bldg. _____ Street _____ City _____ State _____ Zip Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Province or Country (if not U.S.) _____		Apt./Bldg. _____ Street _____ City _____ State _____ Zip Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Province or Country (if not U.S.) _____

Is this new address a business address?  Yes  No  
**Failure to answer this question will result in your address being deemed a business address and, therefore, public information.**

**Section III: Name Change (please print)** If you are reporting a name change, please sign using your **NEW** name in Section IV. Your new signature must be notarized for any name changes. **If you are currently registered you will receive a new registration certificate.**

Information <u>Currently</u> On Record		New Information
Last Name _____		Last Name _____
First Name _____		First Name _____
Middle or Initial _____		Middle or Initial _____

Check here if you wish to have your existing license parchment replaced with one in your **NEW** name. Enclose your **original parchment** and a **\$10 check or money order** made payable to the New York State Education Department with your request. You will be sent a new parchment.

**Section IV: Affidavit**

*I declare and affirm that the statements above are true, complete, and correct. I understand that any false or misleading information in, or in connection with, my application or this notification may be cause for denial or loss of licensure and may result in criminal prosecution.*

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

**Section V: For Name Changes Only: Notary Certification And Identification**

State of \_\_\_\_\_ County of \_\_\_\_\_ On  
the \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature \_\_\_\_\_

Notary ID number \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Notary Stamp

**Professional Titles Licensed Under Education Law**

(See item #5 on page 1 of the form.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>Acupuncturist</li> <li>Architect</li> <li>Athletic Trainer</li> <li>Audiologist</li> <li>Certified Clinical Laboratory Technician</li> <li>Certified Dental Assistant</li> <li>Certified Histological Technician</li> <li>Certified Public Accountant</li> <li>Certified Shorthand Reporter</li> <li>Chiropractor</li> <li>Clinical Laboratory Technologist</li> <li>Creative Arts Therapist</li> <li>Cytotechnologist</li> <li>Dental Hygienist</li> <li>Dentist</li> <li>Dietitian/Nutritionist</li> <li>Interior Designer</li> </ul> | <ul style="list-style-type: none"> <li>Landscape Architect</li> <li>Land Surveyor</li> <li>Licensed Clinical Social Worker</li> <li>Licensed Master Social Worker</li> <li>Licensed Practical Nurse</li> <li>Marriage and Family Therapist</li> <li>Massage Therapist</li> <li>Medical Physicist</li> <li>Mental Health Counselor</li> <li>Midwife</li> <li>Nurse Practitioner</li> <li>Occupational Therapist</li> <li>Occupational Therapy Assistant</li> <li>Ophthalmic Dispenser</li> <li>Optometrist</li> <li>Pharmacist</li> <li>Physical Therapist</li> </ul> | <ul style="list-style-type: none"> <li>Physical Therapist Assistant</li> <li>Physician</li> <li>Podiatrist</li> <li>Professional Engineer</li> <li>Psychoanalyst</li> <li>Psychologist</li> <li>Public Accountant</li> <li>Registered Physician Assistant</li> <li>Registered Professional Nurse</li> <li>Registered Specialist Assistant</li> <li>Respiratory Therapist</li> <li>Respiratory Therapy Technician</li> <li>Speech-Language Pathologist</li> <li>Veterinarian</li> <li>Veterinary Technician</li> </ul> |
|--|--|---|

**New Applicants**  
**mail to** → New York State Education Department, Office of the Professions, Division of Professional Licensing Services, (insert name of profession from above list) Unit, 89 Washington Avenue, Albany, NY 12234-1000.

**Licensees**  
**mail to** → New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Records and Archives Unit, 89 Washington Avenue, Albany, NY 12234-1000.



**The State Education Department  
Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000**