Clinical Laboratory Technologist/Technician Form 4

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

Applicant Experience Record

(For Grandparenting Applicants Only)

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 7.
2. You must also complete Section I of Form 4A and forward the entire form to each Clinical Laboratory Director you list below.

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 As It Appears On Your Application for Licensure (Form 1)**

Last

First

Middle

4 **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

5 Have you ever changed your name? ☐ **Yes** ☐ **No** If yes, print former name(s): _____

6 Experience Information - Only report hours through 8/31/06

List the Clinical Laboratory Director(s) who will verify your experience as a (check one): ☐ clinical laboratory technologist ☐ clinical laboratory technician

Name of Clinical Laboratory Director	Dates of Experience		Total Clock Hours
	From:	To:	
	From:	To:	
	From:	To:	

7 Attestation

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.

Applicant's Signature: _____ Date:_____ / _____ / _____
mo. day yr.

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.