

Section II: Certification of Experience

Instructions to the Clinical Laboratory Director/Principal Researcher: Complete A and B, sign and date the affirmation and send the entire form along with any additional information 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)

A. Qualifications

I am a Clinical Laboratory Director/Principal Researcher as defined below Yes No

Definition: A "Clinical Laboratory Director" means a "person who is responsible for administration of the technical and scientific operation of a clinical laboratory or blood bank, including the supervision of procedures and reporting of findings of tests".

Definition: A "Principal Researcher" is the principal investigator who is responsible for the management and integrity of the design, conduct, and reporting of the research project and for managing, monitoring, and ensuring the integrity of any collaborative relationships in accordance with all federal and state regulations.

B. Training/Experience Information

Did the above named applicant complete such training/experience as indicated in Section I, item 7? Yes No

Name of setting where training/experience took place _____

Address of setting where training/experience took place _____

Dates of Training/Experience From _____ to _____ Total clock hours: _____
mo. day yr. mo. day yr.

If the applicant served as a research assistant in a research laboratory, please attach a brief description of the research that the applicant was involved in during the time of the experience.

Did the above named applicant receive a certificate or similar document? Yes No

Title of certificate or similar document _____

Date Received _____
mo. day yr.

Affirmation of Clinical Laboratory Director/Principal Researcher

I have reviewed the information presented by the applicant on this form. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work experience and ability and that the work experience described by the applicant is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

Signature _____ Date _____

Print Name _____

Title _____

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.