



**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.**