Cytotechnologist
Certified Histological Technician
Form 2

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

Certification of Professional Education

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Sign and date item 9.
2. Send the entire form to the institution(s) you attended and ask the registrar to complete the appropriate parts of Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required by the institution. **This form will not be accepted if submitted by the applicant.**
3. An official transcript or marksheets are required if you completed a program that is not registered by the Department as licensure qualifying at the time of your graduation.

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 Print your name as it appears on your degree or advanced certificate.

Name: _____

6 School attended: _____
(Name) *(city/state or country)*

7 Name of degree/advanced certificate: _____

8 Date of degree/advanced certificate: _____ / _____ / _____
mo. day yr.

9 I request and give my permission to the school listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

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

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 - Cytotechnologist/Certified Histological Technician Program Registered by the New York State Education Department (NYSED) as licensure qualifying: To be completed only by those schools whose cytotechnologist/certified histological technician 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/advanced certificate of
mo. day yr.

_____ on the date of _____ / _____ / _____,
(Title of degree/advanced certificate) mo. day yr.

OR

☐ on _____ / _____ / _____ this institution determined that the above-named student met all requirements for the
mo. day yr.
degree/advanced certificate and the institution has agreed to award the degree/advanced certificate of

_____
. *(Title of degree/advanced certificate)*

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

1. Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school:

   Entrance date: _____ / _____ / _____ ☐ Completion date: _____ / _____ / _____ ☐ Withdrawal date: _____ / _____ / _____
   mo. day yr. mo. day yr. mo. day yr.

2. Title of degree/advanced certificate awarded: _____

3. Date degree/advanced certificate awarded: _____ / _____ / _____
   mo. day yr.

   Name of accrediting body or official organization that recognizes this program: _____

   Date of Accreditation: _____
   Year

   Address of accrediting body or official organization that recognizes this program: _____

   _____

Part C - Certification

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

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Title or Official Position: _____

Institution: _____

Address: _____ **(SEAL)**

City: _____ State _____ Zip Code _____

Telephone: _____ Fax: _____

E-mail Address: _____

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