

**Cytotechnologist
Certified Histological Technician
Form 5**

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 Limited Permit

Applicant Instructions

1. A limited permit authorizes practice as a cytotechnologist or certified histological technician under the general supervision of Clinical Laboratory Director. Complete Section I. Be sure to sign and date item 9. It is your responsibility to ensure that your employer fully completes Section II.
2. You may apply for a limited permit either at the same time as or after submitting an application for a license as a cytotechnologist or certified histological technician in New York State. If you have not yet filed an Application for Licensure (Form 1) and the licensure fee (\$371 for cytotechnologist; \$263 for certified histological technician), you must submit them with this form and the limited permit fee. **Permits cannot be issued until all required documentation has been received and approved.**
3. Submit this application and the \$50 fee to the Office of the Professions at the address at the end of this form. The limited permit fee is not refundable.
4. If you change supervisors or have additional supervisors after a permit is issued, you must obtain an amended permit. Complete a new Form 5 with each prospective supervisor, and return it to the Office of the Professions. A new fee is not required for a permit issued as a result of a change in supervisor/employer.
5. The limited permit is valid for a period of one year. The permit may be renewed for one additional year if the applicant can document good cause, such as a specific physical or mental disability certified by an appropriate health care professional or other good cause which, in the judgement of the Department, made it impossible for the applicant to complete the examination required for licensure.

Permit Number

Date Issued

Date Expires

Initials

6 Telephone/E-Mail Address

Daytime phone

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Area Code Phone

E-mail Address (please print clearly)

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- If we may discuss your licensure using this e-mail address, please check this box.

7 I am applying for:

- Original permit
- Renewal of Original Permit (Attach justification)
- Additional supervisor/employer
- Change of supervisor/employer

Section I: Applicant Information

1 Check what you are applying for:

Cytotechnologist

93	\$50	PR
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Certified Histological Technician

91	\$50	PR
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2 Social Security Number

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

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3 Birth Date

Month

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Day

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Year

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4 Print Name As It Appears On Your Application for Licensure (Form 1)

Last

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First

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Middle

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

Line 1

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Line 2

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Line 3

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City

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State

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 Zip Code

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Country/Province

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8 Name of prospective supervising Clinical Laboratory Director: _____

9 Attestation

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of permit and licensure and may result in criminal prosecution.

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

Section II: Clinical Laboratory Director's Certification of Employment

A limited permit may be issued to an applicant who has met all requirements for licensure except the licensing examination. The permit is valid for one year, and may not be extended, but may be renewed for one additional year for good cause as determined by the Department. **The applicant named in Section I is seeking a limited permit to practice as a cytotechnologist or certified histological technician in New York State. Complete the information below to certify that the applicant will be employed by the facility or in the setting described.**

1. Applicant's name: _____

2. Name of Director of a Clinical Laboratory with a certificate of qualification issued by the NYS Department of Health:

(print full name - no initials)

Facility name: _____

Address: _____

3. Telephone: _____ Fax: _____

4. E-mail Address: _____

5. Title under which the applicant will be employed: _____

Attestation of Clinical Laboratory Director

I declare that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in or in connection with this certification may be the cause for denial of permit and licensure.

Clinical Laboratory Director's signature: _____ Date _____ / _____ / _____
mo. day yr.

Print full name: _____

Title: _____

Number of Certificate of Qualification issued by NYS Department of Health: _____

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.