NEW YORK STATE DEPARTMENT OF HEALTH
Clinical Laboratory Evaluation Program
Biggs Lab – Wadsworth Center
Empire State Plaza
Albany, NY 12237

E-mail: CLEPCQ@health.ny.gov
Web: www.wadsworth.org/regulatory/clep

Certificate of Qualification Questionnaire

Parasitology
Page 1

Instructions: Complete in full for testing you personally performed, supervised and/or directed. Obtain all appropriate signatures and submit this form along with any applicable letters of documentation to the NYS Department of Health at the address listed above.

Name _____ CQ Code (if known)_____

Name of facility _____ PFI/CLIA#_____

If your recent experience is with urogenital wet mounts only, skip to section 2.

SECTION 1 – General Parasitology

Test	Specimen source	Dates (MM/YY-MM/YY)	Volume for dates listed	Instrument/manufacturer	FDA-Approved* Yes/No

*FDA-Approved assays include those cleared (510k), approved (PMA), exempted, or with Emergency Use Authorization (EUA) by the United States Food and Drug Administration (FDA) that have not been modified to change the procedure or the intended use. Investigational Use Only (IUO)-labeled tests are ONLY included when utilized under a specific FDA Investigational Device Exemption (IDE).

Describe your responsibilities with respect to parasitology testing:

Is/Was all testing listed in the above table performed under your direct supervision? ☐ Yes ☐ No

If No, what percentage was under your direct supervision? _____ Under whose direct supervision (physician or doctoral level director) is/was the remaining testing performed? _____

NEW YORK STATE DEPARTMENT OF HEALTH
Clinical Laboratory Evaluation Program
Wadsworth Center
Empire State Plaza
Albany, NY 12237

E-mail: CLEPCQ@health.ny.org
Web: www.wadsworth.org/regulatory/clep

Parasitology
Page 2

SECTION 2 – Wet Mounts

Dates (MM/YY-MM/YY)	Total Wet Mounts	Number of Positive

Describe your exact responsibilities pertinent to performing urogenital wet smears for the presence of *Trichomonas vaginalis*:

Is/Was all testing listed in the above table performed under your direct supervision? ☐ Yes ☐ No

If No, what percentage was under your direct supervision? _____ Under whose direct supervision (physician or doctoral level director) is/was the remaining testing performed? _____

The applicant and supervisor/director must print and sign their names below to attest that the testing above was performed by and/or under direct supervision by the applicant.

Print applicant name	Applicant signature	Date
Print supervisor/director name	Supervisor/director signature	Date

Supervisor/director's relationship to applicant (e.g. direct supervisor) and how this allows attestation of the applicant's training and/or experience