NEW YORK STATE DEPARTMENT OF HEALTH
Clinical Laboratory Evaluation Program
E-mail: CLEPCQ@health.ny.gov
Web: www.wadsworth.org/regulatory/clep

Technical Director
Certificate of Qualification
Questionnaire

Blood Banking Collection - Limited

Instructions:	Complete in full for collections 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#_____

Dates involved in collection at the above facility (MM/YY-MM/YY)_____

Number of collections each year	20___ *	20___	20___	20___	20___	20___
Allogeneic whole blood						
Autogeneic whole blood						
Pheresis components **						

* If current year exceeds 1000 total units, other years need not be entered.
** Do not include therapeutic pheresis procedures.

Is/was collection under your **direct** supervision? ☐ Yes ☐ No

Describe your responsibilities pertinent to blood collection:

The applicant and supervisor/director must print and sign their names below to attest that the collections above were 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