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

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

**Certificate of Qualification Questionnaire**

# Bacteriology

| Instructions: | Complete in full for testing that you have 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 _____

| Tests and specimen sources (where applicable) | Source | Dates (mo/yr-mo/yr) | Tests per Year | Instrument/ Platform | Method/Chemistry FDA approved or LDT |
|---|---|---|---|---|---|
| Antigen Detection Specify organism | | | | | |
| | | | | | |
| | | | | | |
| Gram Stains | | | | | |
| Aerobic Cultures | | | | | |
| Anaerobic Cultures | | | | | |
| Chlamydia and Gonorrhea Testing | | | | | |
| Molecular-Based Testing-Specify organism or target (Add additional page if needed) | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Susceptibility Testing | | | | | |
| | | | | | |
| Other (list): | | | | | |

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

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