

**PLEASE RETURN THE COMPLETED AND SIGNED FORM BY ONE METHOD ONLY:
fax (518) 449-6902 or email clepltd@health.ny.gov.**

LABORATORY INFORMATION:		
Laboratory PFI Number:		
Laboratory Name:		
Laboratory Address:		
City:	State:	ZIP Code:

FORMER LABORATORY DIRECTOR INFORMATION: Complete this section in its entirety for the FORMER individual providing technical and clinical direction of your laboratory testing.		Effective date former directorship ended:	
Former Laboratory Director Name:			

NEW LABORATORY DIRECTOR INFORMATION: Complete this section in its entirety for the NEW individual providing technical and clinical direction of your laboratory testing.		Effective date of new directorship:	
First Name:	M.I.	Last Name:	
Do you currently hold a New York State Certificate of Qualification (CQ) as a Laboratory Director?			
<input type="checkbox"/> Yes CQ Code: _____ <input type="checkbox"/> No			
Degree(s) and License(s) Held (Include Copy of Current New York State Professional License):			
<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> D.P.M. <input type="checkbox"/> D.D.S. <input type="checkbox"/> Ph.D. <input type="checkbox"/> O.D. <input type="checkbox"/> D.Sc. <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> CNM <input type="checkbox"/> PharmD <input type="checkbox"/> RPh.			
New York State Professional License Number (6 digit): _____			
Home E-mail Address:		Work E-mail Address:	

CERTIFICATION: By signing this form, I hereby certify that the information given is true and correct. I attest that I have reviewed a copy of the most current Limited Service Laboratory Registration application on file with the Department for this laboratory, and will comply with the requirements of Section 579 of the Public Health Law. I also assume responsibility for any laboratory testing performed at secondary testing sites covered under this CUA Number and Limited Service Laboratory Registration. **NOTE: All signatures must be original. SIGNATURE STAMPS WILL NOT BE ACCEPTED.**

_____	_____	_____
Date	Signature, Laboratory Director	Name, Laboratory Director (Print)
_____	_____	_____
Date	Signature, Owner/Representative	Name, Owner/Representative (Print)