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

Certificate of Qualification Questionnaire

Parasitology

Instructions:	**Complete in full and obtain all appropriate signatures as indicated on page 2.** This form along with any applicable letters of documentation should be submitted to the NYS Department of Health at the address listed above.

Name _____ CQ Code (if known)_____

Name of facility _____

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

SECTION 1 – General Parasitology

	Assay	Manufacturer or Platform	Test volume and year 20____	Test volume and year 20____	Test volume and year 20____
Intestinal	*eg. GI Panel*	*Biofire*			
Bloodborne	*eg. Giemsa Stain*	*Trend*			
Helminths					
Arthropods					

Describe your responsibilities with respect to parasitology testing:

Is/Was all of the 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 (doctoral level director) is/was the remaining testing performed?_____

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SECTION 2 – Wet Mounts

	20___	20___	20___
Total Wet Mounts			
Number of Positive			

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

Are/Were all of the wet mounts listed above performed under your direct supervision? ☐ Yes ☐ No

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

The applicant and supervisor/director must print and sign their names below.

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