

# C-14 Certificate of Fitness WCM Alternate Issuance Application



Applicant Information:		
First Name:	Last Name:	
Social Security Number (required by FDNY):		
Phone #:	Email Address:	
Date of Birth (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Weight (pounds):	Height (feet/inches):	
Applicant Mailing (Home) Address:		
Street:	Apt #:	
City:	State:	Zip Code:
Borough: <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island <input type="checkbox"/> Outside New York City		
Work Address (location where C14 COF holder will be working):		
Street:	Room #:	
City:	State:	Zip Code:
Borough: <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island		
Applicant Education and Training Qualifications <i>(select the most appropriate choice and provide copy of license, degree, or other proof of qualifications)</i>		
<input type="checkbox"/> Clinical Laboratory Director license issued by the New York State Department of Health. <input type="checkbox"/> Doctor of Medicine (MD) OR Doctor of Dental Surgery (DDS). <input type="checkbox"/> Master's or Doctoral degree in Chemistry, Biology, Biochemistry, Environmental or Health Sciences, Medical Technology, Chemical or Environmental Engineering, or related field. <input type="checkbox"/> Bachelor's degree in Chemistry, Biology, Biochemistry, Environmental or Health Sciences, Medical Technology, Chemical or Environmental Engineering, or related field AND two years of post-baccalaureate experience in an operating chemical laboratory. <p style="text-align: center;">Experience: _____ Years      _____ Months</p>		
Signature:		
The above information is true to the best of my knowledge.		
Applicant Name – Print (above)	Signature	Date
Supervisor Name – Print (above)	Signature	Date

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Complete following for using Weill Cornell Medicine fund number to pay FDNY C-14 application fee:

<b>Fund Information:</b>	
Weill Cornell Medicine Fund #:	
<b>Fund Authorized information:</b>	
First Name:	Last Name:
Phone #:	Email Address:
<b>Signature:</b>	
Authorized Signature	Date