ASCP BOARD OF CERTIFICATION®

PHLEBOTOMY STRUCTURED TRAINING DOCUMENTATION FORM (ROUTE 2)

PART I *(To be completed by Applicant)*

Applicant's Name _____ Last Four Digits of Applicant's Social Security # _____

Address _____ E-mail Address _____

_____ ( ) _____
Daytime Telephone Number

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PART II (*MUST be completed and signed by the Program Director in order to be acceptable)*

NOTE: To be completed by the Program Director at the school where you registered and paid tuition. The clinical portion of the two-part program must be arranged by written agreement with the program director and the clinical institution.

This individual, identified above, has applied for the Board of Certification Phlebotomy Technician examination. In order to establish this applicant's eligibility for certification, the following information is necessary:

1. PLEASE COMPLETE:

A. Classroom Instruction - Classroom training site: _____

Date classroom training **started**: Month _____ Date _____ Year _____

Date classroom training **ended**: Month _____ Date _____ Year _____

Please check below if the applicant has satisfactorily completed the following requirements:

____ **40** clock hours of classroom training including anatomy and physiology of the circulatory system, specimen collection, specimen processing and handling, laboratory operations (e.g. safety, quality control, etc.)

B. Clinical Instruction -
Clinical training site at a CMS approved, accredited laboratory*: _____

Date clinical training **started**: Month _____ Date _____ Year _____

Date clinical training **ended**: Month _____ Date _____ Year _____

Please check below if the applicant has satisfactorily completed the following requirements:

____ **100** clinical hours with a minimum of **100** successful, unaided blood collections including:

____ Venipunctures

____ Skin punctures (e.g. fingersticks, heelsticks)

____ Orientation in a CMS approved, accredited laboratory*

*Laboratory accredited by a CMS approved accreditation organization (i.e. AABB, CAP, COLA, DNV, The Joint Commission, etc.)

2. By signing this form, I as the Program Director of the Phlebotomy Technician training program verify that this applicant has satisfactorily completed the two-part Structured Phlebotomy Technician Training Program including all areas checked on this form.

(Please Print) PROGRAM DIRECTOR NAME & CERTIFICATION(S) _____ TITLE _____

PROGRAM DIRECTOR SIGNATURE _____ DATE _____

TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

INSTITUTION _____

CITY _____ STATE _____ ZIP CODE _____

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR PROGRAM DIRECTOR WITH THIS TRAINING DOCUMENTATION FORM. THE LETTER OF AUTHENTICITY MUST BE PRINTED ON ORIGINAL LETTERHEAD. IT MUST STATE THAT THE TRAINING DOCUMENTATION FORM WAS COMPLETED, SIGNED, AND DATED BY YOUR PROGRAM DIRECTOR.

BOC 4/14