EXAMINATION SCORE AUTHORIZATION CALIFORNIA RESIDENTS

TYPE or **PRINT** the following information and mail this form to the address shown below.

Certifying Agency Name: **ASCP – Board of Certification**
33 West Monroe St, Suite 1600
Chicago, IL 60603

I am authorizing the certifying agency listed above to release my examination scores, **pass or fail**, and certification number to the California Department of Health Services.

Name: _____
(Last) (First) (M.I.)

Signature: _____

Customer ID # ___ ___ ___ ___ ___ ___ ___ ___ ___

Last four digits of your Social Security Number: ___ ___ ___ ___ **(Required)**

Certification Category: ____**PHLEBOTOMY**_____

Name at time of certification: _____
(**Note:** If your name at the time of certification is different than your current name, you must submit documentation in the form of a marriage license, divorce decree or other court order along with this form before your request will be fulfilled. Copies are acceptable.)

The form must be returned before the date of your examination.

Please mail this authorization form to:

Board of Certification
Attn: Iris McLemore
33 West Monroe
Suite 1600
Chicago, IL 60603