



**CALIFORNIA APPROVED PHLEBOTOMY PROGRAM
REFERENCE FORM
(ROUTE 1)**

PART I (To be completed by Applicant)

Applicant's Name

Social Security #

Address

E-mail Address

City, State, Zip

(____)_____
Daytime Telephone Number

PART II (To be completed by Program Official)

SUBJECT: Verification of successful completion of a phlebotomy program approved by the California Department of Public Health.

This applicant has successfully completed a phlebotomy program approved by the California Department of Public Health and has been awarded a Certification of Completion within the last five years.

Name of Program

Date Program Began

Date Program Ended

By signing this form, I verify that this applicant has completed the above phlebotomy program within the last five years. This form must be completed and signed by the Program Official of the phlebotomy program approved by the California Department of Public Health or it will not be acceptable.

(Please Print) Program Official's Name

Title

Program Official's Signature

Date

(____)_____
Telephone Number

E-mail Address

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR PROGRAM OFFICIAL WITH THIS REFERENCE FORM. THE LETTER OF AUTHENTICITY MUST BE PRINTED ON ORIGINAL LETTERHEAD; STATE THAT THIS REFERENCE FORM WAS COMPLETED BY YOUR PROGRAM OFFICIAL AND INCLUDE THE DATE AND YOUR PROGRAM OFFICIAL'S SIGNATURE.