



ASCP Board of Registry
 Suite 1600
 33 W Monroe St
 Chicago, IL 60603
 (312) 541-4979

**EVALUATION FORM FOR STRUCTURED PROGRAMS IN
 TECHNOLOGIST IN HEMATOLOGY
 (Route 3)**

STUDENT'S NAME _____

SOCIAL SECURITY NUMBER _____

NAME OF PROGRAM _____

Please indicate: _____ Quarter hours _____ Semester hours

	COURSE TITLE 30 semester hours (45 quarter hours)	CREDIT HOURS COMPLETED	CREDIT HOURS IN PROGRESS
BIOLOGY/CHEMISTRY:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Additional Comments: _____

LENGTH OF STRUCTURED PROGRAM (in months) _____ **TYPE OF DEGREE** _____

EXPECTED DATE OF COMPLETION _____ **DATE OF COMPLETION OF**
 (Month) (Day) (Year) **DEGREE REQUIREMENTS** _____

This is to document that the above named student has successfully completed the current minimum academic requirements for the Board of Registry Technologist in Hematology examination as checked and listed above, and has completed or will complete a baccalaureate degree by the examination date. I verify that the above named student is enrolled in a structured program in Hematology (one academic year in length) which is equivalent to the curriculum for Hematology in the NAACLS accredited Medical Technology Program at the above named institution and that this student will successfully complete the structured program in Hematology prior to the examination date. I agree to notify the Board of Registry promptly if the student fails to complete any of the conditions stipulated above.

 (Please Print) PROGRAM OFFICIAL TITLE DATE

PROGRAM OFFICIAL'S SIGNATURE _____

NAME OF PROGRAM _____

SCHOOL IDENTIFICATION NUMBER _____

TELEPHONE NUMBER (_____) _____ EMAIL ADDRESS _____

INSTITUTION _____

ADDRESS _____

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