



PART I (To be completed by Applicant)

_____	_____
Applicant's Name	Social Security #
_____	_____
Address	E-mail Address
_____	() _____
	Daytime Telephone Number

PART II (To be completed by Employer)

SUBJECT: Verification of Experience for Examination Eligibility

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

I. Please complete
EMPLOYMENT (including on-the-job training)

Date employment started in Hematology Month _____ Day _____ Year _____

Date employment ended in Hematology Month _____ Day _____ Year _____

How many hours per week in Hematology? _____

II. Please place an X by each of the procedures which have been performed satisfactorily under your supervision by this applicant. (Experience is required in all of the procedures listed)

- | | |
|-------------------------------------------------------------------|----------------------------------------------------------------|
| _____ Blood smear, evaluation and differential | _____ Quality Control: performance and evaluation |
| _____ Complete Blood Count | _____ Routine coagulation tests (e.g. PT, APTT) |
| _____ Instrument maintenance | _____ Other coagulation tests (e.g. fibrinogen, factor assays) |
| _____ Miscellaneous Tests (e.g. reticulocyte, ESR, sickle screen) | |

III. Please place an X by each of the procedures the applicant has **performed, supervised or taught**. (Experience is required in 5 of the 12 procedures listed.)

- | | |
|----------------------------------------------------|-----------------------------------|
| _____ Advanced coagulation (e.g. inhibitor assays) | _____ Hemoglobinopathy evaluation |
| _____ Body fluid evaluation | _____ Method evaluation |
| _____ Bone marrow prep or evaluation | _____ Personnel management |
| _____ Budgeting/inventory control/purchasing | _____ Platelet function studies |
| _____ Cytochemical stains | _____ PT/PTT mixing studies |
| _____ Flow Cytometry | _____ QA/QI |

(over)

III. *This form must be completed and signed by the Laboratory Director (Physician or Medical Scientist or the supervising certified Medical Technologist) or it will not be acceptable.* By signing this form, I verify that this applicant has performed satisfactorily in the areas checked on the reverse side.

(Please Print) LABORATORY DIRECTOR'S or SUPERVISOR'S NAME, TITLE AND CERTIFICATION

DATE

LABORATORY DIRECTOR'S or SUPERVISOR'S SIGNATURE

TELEPHONE NUMBER

E-MAIL ADDRESS

INSTITUTION

CITY STATE

ZIP CODE

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

BOC10/09