EXAMINATION SCORE AUTHORIZATION CALIFORNIA RESIDENTS

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

Certifying Agency Name: **American Society for Clinical Pathology**
33 West Monroe
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.

Applicant's Name_____
(Last) (First) (M.I.) (Maiden)

Applicant's Signature:_____

Social Security Number:_____

Certification Category: Phlebotomy

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

Please mail this authorization form to:

American Society for Clinical Pathology
Board of Certification
33 West Monroe
Suite 1600
Chicago, IL 60603

Attn: Iris McLemore

Rev. 10/09