CALIFORNIA RESIDENTS
EXAMINATION SCORE AUTHORIZATION

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.

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

Signature: _____

California ID Number: ☐☐☐☐☐☐

Social Security Number: _____

Certification Category: _____

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
33 West Monroe
Suite 1600
Chicago, IL 60603