IMPORTANT
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REVALIDATION APPLICATION PROCEDURES FOR THE QUALIFICATION IN CYTOMETRY (QCYM)

REVALIDATION APPLICATION FEES ARE NONREFUNDABLE

Requirements for Revalidations for Your Qualification

In order to revalidate your Qualification, you must have completed 30 contact hours of continuing education courses related to cytometry within the five year period for which your qualification is valid. If you do not complete the required 30 contact hours within this five year time frame, you must reapply for the Qualification, meet the current eligibility requirements and successfully complete an online examination (i.e. if an individual received his Certificate of Qualification in June 2002, his Qualification is valid until June 2007). Thirty contact hours must be completed between June 2002 and June 2007 in order to revalidate this qualification from 2002 – 2007. If these hours are not completed within this specific time frame (2002 – 2007), you must reapply for the Qualification. It is your responsibility to submit the Certificates of Completion to the Board of Registry by the organizations granting the contact hours.

Deadline Date

Your application form, fee and documentation of 30 contact hours of continuing education courses must be submitted to our office **before** the date your current Qualification expires.

Acknowledgment of Application

Upon receipt in the ASCP/Board of Registry office, your revalidation application form and fee will be acknowledged within six (6) weeks of receipt. Do not contact the Board of Registry office regarding receipt of your application and fee until 45 business days following submission to allow processing. If you do not receive an acknowledgment within six (6) weeks from the date you submitted your application, please notify our office by e-mail: bor@ascp.org OR fax 312.541.4845.

Ineligibility

If you are not determined eligible for revalidation, you will receive a written notification. Revalidation application fees are non-refundable. Be sure you have met the requirements as stated and are able to provide the appropriate documentation before submitting your revalidation application form and fee.

Change of name and/or Address

If you change your address, notify the ASCP/Board of Registry Office by email to bor@ascp.org; fax 312.541.4845 or mail to the general correspondence address below. Name and address changes should **NOT** be made online through the ASCP web site. Name changes must be accompanied by a photo copy of your marriage license or court order and mailed to general correspondence address below.

Mailing Addresses

Revalidation Application/Fee/Credit Card

ASCP/Board of Registry, 3335 Eagle Way, Chicago, Il 60678-1033

General Correspondence

ASCP/Board of Registry 33 W. Monroe Street, Suite 1600, Chicago, IL 60603

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APPLICATION
FOR REVALIDATION OF
QUALIFICATION IN CYTOMETRY
(QCYM)

Instructions for Completing Application

1. To prevent delay in processing your application, carefully and completely fill in all information blanks that apply to you. If the requested information does not apply to you, enter N/A (not applicable) where appropriate.

2. Be sure to sign the application form on the reverse side.

3. Include with your application, a check/money order for $50 payable to "**Board of Registry**". (DO NOT SEND CASH.) All fees must be submitted in U.S. currency. If you are paying by credit card, be sure to completely fill in Section 1. **DO NOT FAX THE APPLICATION FORM.** Your application will be returned to you if it is not accompanied by a fee OR credit card information.

4. Fees paid by Employers/Institutions – Your application will be returned to you if it is not accompanied by a personal check or credit card information. Purchase Orders or Vouchers will not be accepted for application fees. All checks must accompany the application form.

5. Enclose documentation of 30 contact hours of continuing education courses related to cytometry in the form of certificates of completion or other appropriate documentation with your application. These certificates/documentation should include the name of the course/program provider and be signed by an authorized individual. The certificate/documentation must include credit or contact hours along with the title and date of the course. These hours must be completed during the time period from the date your Qualification was issued and the date your Qualification expires.

6. When you have completed the application form, mail the application, documentation of continuing education credits and the $50 fee (check or credit card) to: **Board of Registry, 3335 Eagle Way, Chicago, IL 60678-1033.**

1. PAYMENT INFORMATION:

☐ **Visa** ☐ **Master Card** ☐ **American Express**

CREDIT CARD # ____ - ____ - ____ - ____

Expiration Date __ / __ **Fee Amount $** 50

SIGNATURE ______________________________

2. PERSONAL INFORMATION: MUST BE FILLED OUT COMPLETELY (Type or Print Plainly)

U.S. SOCIAL SECURITY NUMBER ___ - __ - ____

DAYTIME TELEPHONE NUMBER (with area code) ___ - ___ - ____

EMAIL ADDRESS ______________________________

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

LAST NAME, FIRST NAME, MIDDLE INITIAL
(Please print name as you wish it to appear on your certificate)
____

MAIDEN NAME IF APPLICABLE ______________________________

ADDRESS ______________________________
____

CITY (COUNTRY IF FOREIGN) ______________ **STATE** __ **ZIP** _____ - ____

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3. DOCUMENTATION OF CONTINUING EDUCATION

List the continuing education courses which you have completed within the five year qualification period. Thirty (30) contact hours of continuing education related to cytometry must be completed **between** the date the Qualification was issued and the date the Qualification expires.

Date Qualification was issued ________________________ **Date Qualification Expires** ______________________

Course Provider	Course Title	Number of Contact Hrs.	Date of Completion

Attach documentation of these continuing education courses. Documentation must be in the form of an original or copy of a certificate or other appropriate documentation with contact or credit hours printed on the form along with the title, date of the course, course/provider name and signature of an authorized individual.

By submitting and signing this application, I acknowledge that this application will be reviewed and processed, and that an evaluation will be conducted in accordance with the rules and policies adopted by the Board of Registry. I agree to hold harmless the members, examiners, officers and agents of the Board of Registry from any and all actions that they may take, or refrain from taking, pursuant to such rules and policies.

I certify that all information contained in this application, as well as any information that I submit in support of this application is true and correct to the best of my knowledge and belief. I authorize representatives of the Board of Registry to verify the accuracy of any information contained in, or supplied in support of, this application from any person or persons having knowledge of such information. I recognize that this qualification, if granted, is based on the correctness of the information contained in, and supplied in support of, this application.

I further recognize that revalidation of qualification, if granted, may be revoked at any time if it is established that the information contained in, or supplied in support of, this application is inaccurate in any material respect, or if I misrepresent or misuse my qualification status. I understand the revalidation of qualification in cytometry, if granted, is valid for a period of five years.

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Applicant's Signature   Date

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