



ASCP Board of Registry
 Suite 1600
 33 W Monroe St
 Chicago, IL 60603
 (312) 541-4956

**MEDICAL LABORATORY TECHNICIAN
 REFERENCE FORM
 (Route 4)**

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 Board of Registry Certification as a Medical Laboratory Technician. In order to establish this applicant's eligibility for examination, the following information is necessary.

I. Please complete

EMPLOYMENT (including on-the-job training)

Date employment started Month ____ Day ____ Year ____

Date employment ended Month ____ Day ____ Year ____

How many hours per week? _____
 (average if necessary)

II. I verify that under my supervision this applicant has demonstrated proficiency in each area checked below.

Blood Banking _____ Microbiology _____

Chemistry _____ Immunology _____

Hematology _____ Clinical Microscopy _____

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 above.*

 (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.