



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

MEDICAL TECHNOLOGIST
REFERENCE FORM
(Route 2, 3 & 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 Technologist. 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 moderate and high complexity testing including pre- and post-analytical components 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.