



**ASCP Board of Registry**  
 Suite 1600  
 33 W Monroe St  
 Chicago, IL 60603  
 (312) 541-4979

**SPECIALIST IN CYTOTECHNOLOGY  
 REFERENCE FORM  
 (Route 1)**

**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 Specialist in Cytotechnology. In order to establish this applicant's eligibility for examination, the following information is necessary. This form must be completed and signed by the Laboratory Director (Physician or Medical Scientist).

I. Please complete

**EMPLOYMENT** (including on-the-job training)

Date employment started in Cytotechnology. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Date employment ended in Cytotechnology. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How many hours per week in Cytotechnology? \_\_\_\_\_

II. By signing this form, I verify that this applicant has performed satisfactorily in the area of Cytotechnology.

\_\_\_\_\_  
 (Please Print) LABORATORY DIRECTOR'S or SUPERVISOR'S NAME, TITLE AND CERTIFICATION

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 LABORATORY DIRECTOR'S or SUPERVISOR'S SIGNATURE, TITLE AND CERTIFICATION

\_\_\_\_\_  
 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.**