INTERNATIONAL PHLEBOTOMY TECHNICIAN

TRAINING DOCUMENTATION FORM (Route 1)

PART I (TO BE COMPLETED BY APPLICANT)

Applicant's Name _____ Address _____

Email Address _____

PART II (MUST be completed and signed by Program Director in order to be acceptable.)

NOTE: TO BE COMPLETED BY THE PROGRAM DIRECTOR AT THE SCHOOL WHERE YOU REGISTERED AND PAID TUITION.

This individual, identified above, has applied for the Board of Certification International Phlebotomy examination. In order to establish this applicant's eligibility for certification, the following information is necessary:

1. **PLEASE COMPLETE:**

   A. **CLASSROOM INSTRUCTION - CLASSROOM TRAINING SITE:** _____

   Date classroom training **started**: Month _____ Day _____ Year _____

   Date classroom training **ended**: Month _____ Day _____ Year _____

   PLEASE CHECK BELOW IF THE APPLICANT HAS SATISFACTORILY COMPLETED THE FOLLOWING REQUIREMENTS. ALL AREAS ARE REQUIRED.

   _____ **40** clock hours of classroom training including:

   _____ Anatomy and physiology of the circulatory system

   _____ Laboratory operations (e.g., safety, quality control, etc.)

   _____ Specimen processing and handling

   _____ Specimen collection (including venipunctures and skin punctures)

   B. **CLINICAL INSTRUCTION :**

   CLINICAL TRAINING SITE AT AN APPROVED, ACCREDITED LABORATORY*: _____

   Date clinical training **started**: Month _____ Day _____ Year _____

   Date clinical training **ended**: Month _____ Day _____ Year _____

   PLEASE CHECK BELOW IF THE APPLICANT HAS SATISFACTORILY COMPLETED THE FOLLOWING REQUIREMENTS. ALL AREAS ARE REQUIRED.

   _____ **100** clinical hours including:

   _____ Minimum performance of **100** unaided venipunctures

2. **BY SIGNING THIS FORM, I AS THE PROGRAM DIRECTOR OF THE PHLEBOTOMY TECHNICIAN TRAINING PROGRAM VERIFY THAT THIS APPLICANT HAS SATISFACTORILY COMPLETED THE PHLEBOTOMY TECHNICIAN TRAINING PROGRAM INCLUDING ALL AREAS CHECKED ON THIS FORM.**

(Please Print) Program Director's Name _____ Title _____

Program Director Signature _____ Date _____

Name of Program _____ Program Director's Email Address _____

Institution _____ Institution Telephone Number _____

Institution Address _____

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR PROGRAM DIRECTOR WITH THIS TRAINING DOCUMENTATION FORM. THE LETTER OF AUTHENTICITY MUST BE PRINTED ON ORIGINAL LETTERHEAD. IT MUST STATE THAT THE TRAINING DOCUMENTATION FORM WAS COMPLETED, SIGNED, AND DATED BY YOUR PROGRAM DIRECTOR. TRAINING DOCUMENTATION FORMS RECEIVED WITHOUT LETTERS OF AUTHENTICITY ARE UNACCEPTABLE. PLEASE EMAIL THESE FORMS TO ASCP INTERNATIONAL: ascpinternational@ascp.org