

Institution Address



INTERNATIONAL SPECIALIST IN CYTOLOGY

EDUCATOR EXPERIENCE DOCUMENTATION FORM (Route 2)

PART I (TO BE COMPLETED BY APPLICANT)

Applicant's Name	ASCP Customer ID #	
Email Address	Address	
PART II (MUST BE COMPLETED AND SIGNED BY IMM ACCEPTABLE)	MEDIATE SUPERVISOR OR EMPLOYER IN ORDER TO BE	
SUBJECT: VERIFICATION OF EDUCATOR EXPERIENCE FOR E This individual, identified above, has applied for the Board of n order to establish this applicant's eligibility for certification	of Certification International Specialist in Cytology examination.	
I. PLEASE COMPLETE: EMPLOYMENT		
Date teaching employment started : Month	Day Year	
Date teaching employment ended : Month	Day Year	
Are you employed full time or part time a	as an educator? If part time, how many hours per week?	
How many Cytology courses do you teach per school year	r?	
2. BY SIGNING THIS FORM, I AS IMMEDIATE SUPERVISOR SATISFACTORILY IN THE AREA OF CYTOLOGY.	R OR EMPLOYER VERIFY THAT THIS APPLICANT HAS TAUGHT	
(Please Print) Immediate Supervisor or Employer Name	Title	
Immediate Supervisor or Employer Signature	Date	
Immediate Supervisor or Employer Email Address	Institution Telephone Number	
Institution		

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR IMMEDIATE SUPERVISOR OR EMPLOYER WITH THIS EDUCATOR EXPERIENCE DOCUMENTATION FORM. THE LETTER OF AUTHENTICITY MUST BE PRINTED ON ORIGINAL LETTERHEAD. IT MUST STATE THAT THE EDUCATOR EXPERIENCE DOCUMENTATION FORM WAS COMPLETED, SIGNED AND DATED BY YOUR IMMEDIATE SUPERVISOR OR EMPLOYER. EDUCATOR EXPERIENCE DOCUMENTATION FORMS RECEIVED WITHOUT LETTERS OF AUTHENTICITY ARE UNACCEPTABLE.

See www.ascp.org/boc/intl-documentation for submission instructions.