ASCP BOC ASCP BOARD OF CERTIFICATION

MEDICAL LABORATORY ASSISTANT

STRUCTURED PROGRAM DOCUMENTATION FORM (Route 6)

PART I (TO BE COMPLETED BY APPLICANT)

Applicant's Name _____ Last Four Digits of Applicant's Social Security # _____

Address _____ Email Address _____

Daytime Telephone Number _____

PART II (MUST BE COMPLETED AND SIGNED BY THE PROGRAM DIRECTOR IN ORDER TO BE ACCEPTABLE)

This individual, identified above, has applied for the Board of Certification Medical Laboratory Assistant 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 _____

How many clock hours of classroom training? _____

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 _____

How many hours of clinical training? _____

*CMS CLIA certificate of registration, compliance, accreditation; OR JCI accreditation; OR Accreditation under ISO 15189.

2. BY SIGNING THIS FORM I, AS THE PROGRAM DIRECTOR OF THE MEDICAL LABORATORY ASSISTANT TRAINING PROGRAM, VERIFY THAT THIS APPLICANT HAS SATISFACTORILY COMPLETED THE TWO-PART STRUCTURED MEDICAL LABORATORY ASSISTANT TRAINING PROGRAM.

(Please Print) Program Director Name & Credential(s) _____ Title _____

Program Director Signature _____ Date _____

Telephone Number _____ Email Address _____

Institution _____ 6-digit school code (if applicable) _____

City, State _____ Zip Code _____

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.

ASCP BOARD OF CERTIFICATION

MEDICAL LABORATORY ASSISTANT
WORK EXPERIENCE DOCUMENTATION FORM (Route 6)

PART III (TO BE COMPLETED BY APPLICANT)

Applicant's Name _____ Last Four Digits of Applicant's Social Security # _____

Address _____ Email Address _____

_____ Daytime Telephone Number _____

PART IV (MUST BE COMPLETED AND SIGNED BY THE IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* IN ORDER TO BE ACCEPTABLE)

SUBJECT: VERIFICATION OF WORK EXPERIENCE FOR EXAMINATION ELIGIBILITY

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

1. PLEASE COMPLETE: EMPLOYMENT (INCLUDING ON-THE-JOB TRAINING)

Date employment **started** as a medical laboratory assistant: Month _____ Day _____ Year _____

Date employment **ended** as a medical laboratory assistant: Month _____ Day _____ Year _____

How many hours per week worked as a medical laboratory assistant? _____

2. DIRECTIONS: Please review the work experience of this applicant. Please place an **X** next to each area to verify the applicant has performed satisfactorily in **ALL** of the following areas under your supervision:

_____ Specimen Preparation and Processing (processes related to the handling, transport, and processing of specimens)

_____ Support for Clinical Testing (e.g., slide preparation and staining, microbiology setup and plating, reagent preparation, instrument loading, result reporting, inventory maintenance, quality control)

_____ Laboratory Operations (e.g., regulatory applications, waste disposal, safety, equipment maintenance)

3. BY SIGNING THIS FORM, I AS THE IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* VERIFY THAT THIS APPLICANT HAS PERFORMED SATISFACTORILY AS A MEDICAL LABORATORY ASSISTANT.

(Please Print) Immediate Supervisor or Laboratory Management* Name & Credential(s) _____ Title _____

Immediate Supervisor or Laboratory Management* Signature _____ Date _____

Telephone Number _____ Email Address _____

Institution _____

City, State _____ Zip Code _____

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* WITH THIS WORK EXPERIENCE DOCUMENTATION FORM. THE LETTER OF AUTHENTICITY MUST BE PRINTED ON ORIGINAL LETTERHEAD. IT MUST STATE THAT THE WORK EXPERIENCE DOCUMENTATION FORM WAS COMPLETED, SIGNED AND DATED BY YOUR IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT*.

Management is defined as someone in a management role who can verify technical experience.