ASCP BOARD OF CERTIFICATION

MEDICAL LABORATORY ASSISTANT

STRUCTURED TRAINING 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: _____

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

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

How many hours of clinical training? _____

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 & Certification(s)

Title

Program Director Signature

Date

Telephone Number

Email Address

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.