



# PHLEBOTOMY TECHNICIAN

## STRUCTURED PROGRAM DOCUMENTATION FORM (Route 2)

### PART I (TO BE COMPLETED BY APPLICANT)

Applicant's Name	ASCP Customer ID #
Address	Email Address
City, State, Zip Code	Last Four Digits of Applicant's Social Security #

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

**NOTE: TO BE COMPLETED BY THE PROGRAM OFFICIAL. THE CLINICAL PORTION OF THE TWO-PART PROGRAM MUST BE ARRANGED BY WRITTEN AGREEMENT WITH THE PROGRAM OFFICIAL AND THE CLINICAL INSTITUTION.**

This individual, identified above, has applied for the Board of Certification 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    \_\_\_\_\_ Specimen processing and handling  
 \_\_\_\_\_ Laboratory operations (e.g., safety, quality control, etc.)    \_\_\_\_\_ 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** successful unaided venipunctures  
 \_\_\_\_\_ Orientation in an approved, accredited laboratory\*

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

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

(Please Print) Program Official Name & Credential(s)	Title
Program Official 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 OFFICIAL 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 OFFICIAL.**

See [www.ascp.org/boc/us-documentation](http://www.ascp.org/boc/us-documentation) for submission instructions.