ASCP BOARD OF CERTIFICATION

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

   _____ 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** 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 AND MAILED TO THE ADDRESS BELOW. IT MUST STATE THAT THE TRAINING DOCUMENTATION FORM WAS COMPLETED, SIGNED, AND DATED BY YOUR PROGRAM OFFICIAL.

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