



QUALIFICATION IN APHERESIS WORK EXPERIENCE DOCUMENTATION FORM (Route 5)

PART I (TO BE COMPLETED BY APPLICANT)

Applicant's Name

Last Four Digits of U.S. Social Security # (if applicable)

Address

Email Address

City, State

Zip Code

Country

Daytime Telephone Number

PART II (MUST BE COMPLETED AND SIGNED BY THE RESPONSIBLE SUPERVISING PHYSICIAN IN ORDER TO BE ACCEPTABLE.)

SUBJECT: VERIFICATION OF WORK EXPERIENCE FOR EXAMINATION ELIGIBILITY

This individual, identified above, has applied for the Board of Certification Qualification in Apheresis examination. In order to establish this applicant's eligibility for qualification, the following information is necessary:

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

Date employment **started** in Apheresis: Month _____ Day _____ Year _____

Date employment **ended** in Apheresis: Month _____ Day _____ Year _____

How many hours per week employed? _____ In Apheresis? _____

2. DIRECTIONS: Please review the experience of this applicant. Please place an **X** by each area in which this applicant has demonstrated proficiency under your supervision. Individuals certifying proficiency should have personally observed or reviewed the applicant's work. (NOTE: Experience is required in **ALL** of the areas listed below.)

- _____ Evaluating patients and/or donors for suitability to undergo apheresis procedures
- _____ Writing orders for apheresis procedures
- _____ Supervising apheresis procedures
- _____ Evaluating and managing adverse events during apheresis procedures

3. BY SIGNING THIS FORM, I AS THE RESPONSIBLE SUPERVISING PHYSICIAN, VERIFY THAT THIS APPLICANT HAS PERFORMED SATISFACTORILY IN THE APHERESIS AREAS CHECKED ON THIS FORM.

(Please Print) Responsible Supervising Physician's Name & Certification(s)

Title

Responsible Supervising Physician's Signature

Date

Telephone Number

Email Address

Facility / Institution

Facility / Institution Address

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR RESPONSIBLE SUPERVISING PHYSICIAN WITH THIS EXPERIENCE DOCUMENTATION FORM. THE LETTER OF AUTHENTICITY MUST BE PRINTED ON ORIGINAL LETTERHEAD. IT MUST STATE THAT THE EXPERIENCE DOCUMENTATION FORM WAS COMPLETED, SIGNED AND DATED BY YOUR RESPONSIBLE SUPERVISING PHYSICIAN.