



2021 ASCP GYN PT™ Locum Tenens Enrollment Booklet

*For a CMS-Approved National Gynecologic Cytology
Proficiency Testing Program*

The Centers for Medicare & Medicaid Services (CMS) has approved ASCP's national gynecologic cytology proficiency testing program under the Clinical Laboratory Improvement Amendments (CLIA) of 1988, applicable sections of Subparts H and I.



THE LOCUM TENENS TEST MAY TAKE PLACE AT THE ASCP TESTING FACILITY IN INDIANAPOLIS, INDIANA OR MAY BE SHIPPED TO A SITE THAT IMPLEMENTS PROPER PROCTOR PROTOCOLS AND THE TESTER HAS A WORKING RELATIONSHIP WITH.

Option 1: TESTING FEE. If the event is held at the ASCP testing center in Indianapolis, Indiana, this will be the only charge.

- FEE FOR LOCUM TENENS ASCP GYN PT (PTLT21) TOTAL COST: \$124.29
(ALL TRAVEL EXPENSES ARE THE RESPONSIBILITY OF THE LABORATORY OR INDIVIDUAL)

IMPORTANT: Secondary-screening Pathologists testing at the ASCP Testing Center must bring a cytologist from their home laboratory to mark challenges and provide their initial interpretation of the cases. If a cytologist does not come with the secondary-screening Pathologist, the Pathologist must test as a primary screener.

Option 2: TESTING FEE IF SHIPPED TO SITE. If the test is shipped to an individual to test at a facility with a proctor in place.

- FEE FOR LOCUM TENENS ASCP GYN PT (PTLTS21) TOTAL COST: \$149.29

CONTACT INFORMATION LOCUM TENENS PARTICIPANT

Name _____ E-mail _____
 Phone _____ Fax _____
 Address _____
 City/State/Zip _____
 Alternative Contact _____ Alternative Contact's E-mail _____
 Phone _____ Fax _____

PAYMENT INFORMATION

Total Fee \$ _____
 Check Enclosed (payable to ASCP)
 Purchase Order # _____
 I want to pay by credit card. Please call me at _____ . Date/Time _____

Important!

*For you protection, ASCP no longer gathers credit card info via mail or fax. Please call to give ASCP your credit card information.

CONTACT INFORMATION IF LOCUM IS TESTING AT A LABORATORY

Laboratory Director _____ Laboratory Director's E-mail _____
 Phone _____ Fax _____
 Address _____
 City/State/Zip _____
 Alternative Contact _____ Alternative Contact's E-mail _____
 Phone _____ Fax _____
 Lab Director Signature _____

Complete for each participant being tested

All information related to GYN Proficiency Testing will be handled by employees of ASCP with utmost confidentiality and discretion. Under no circumstances will an individual's results be shared or discussed with an unauthorized individual. All testing results will be sent directly to CMS and the Laboratory Director if testing in association with a laboratory.

PARTICIPANT NAME

First _____ M.I. _____ Last _____

ASCP PTR# (if known): _____

Other name(s) used (maiden name, change of name)

1 _____ 2 _____ 3 _____

Physicians:

M.D. / D.O. (circle one)

Circle ONE category that applies:

- A. Primary Screener of GYN materials (even if one case/year)
- B. Secondary Screener (always screens pre-dotted GYN materials)

If testing at the Testing Center, a secondary screening pathologist must bring a cytologist from their current work facility to pre-screen challenges and provide initial interpretation.

Medical Licensure Number _____

OR State Licensure Number (where PT testing will occur) _____

Cytologist (indicate ONE unique identifying number)

ASCP BOR# _____ OR HEW # _____

OR State Licensure Number(s) _____

IS ENROLLEE CURRENTLY EVALUATING GYN CHALLENGES AT TWO (2) OR MORE LABORATORIES? YES / NO

If YES, provide the following information for each lab. ASCP will forward testing results to each site indicated.

Laboratory Director _____

Laboratory/Hospital _____

Laboratory/Hospital Address _____

City/State/Zip _____

CIRCLE ONE PREPARATION TYPE MOST ROUTINELY EVALUATED BY THIS INDIVIDUAL. THE TEST WILL CONSIST OF 100% OF THE CHOSEN PREP TYPE: C=Conventional T=ThinPrep SP=SurePath

NEW! INDICATE TESTING DATES, IN ORDER OF PREFERENCE 1 _____ 2 _____

ASCP WILL MAKE EVERY EFFORT TO ACCOMMODATE ONE OF YOUR TESTING DATES.



ATTESTATION STATEMENT

I hereby affirm that the information provided with this testing enrollment is true and complete, and includes accurate information.

Signature of Locum Tenens Participant

Date

ENROLLMENT CHECKLIST

- Order Information / Contact, Shipping and Payment Information Form
- Participant Enrollment Forms for personnel required to test
- Attestation Statement
- Payment check (if not paying by PO or credit card)

SUBMISSION INSTRUCTIONS

Make a copy of all enrollment materials for your records

To submit enrollment by

Phone

317.569.9470 (international callers: 312.541.4890)
Monday-Friday (8:00am–4:00pm EST)
Have your email address and credit card available.

Fax*

317.569.0221
Please include email address and a copy of your purchase order with the registration form anytime.

Mail*

ASCP
3462 Eagle Way
Chicago, IL 60678-103
Include email address, a check payable to ASCP, or a completed purchase order.

*For your protection, ASCP no longer gathers credit card info via mail or fax.
Please call to give ASCP your credit card informations.