PART I (To be completed by Applicant)

STUDENT’S NAME ________________________________________________________________

NAME OF PROGRAM ______________________________________________________________

***********************************************************************************************************

PART II (MUST be completed and signed by Program Director in order to be acceptable. All eligible clinical training must be completed outside of the classroom setting as part of their internship, laboratory/industrial posting, clinical rotation, service or practicum)

1. SUBJECT: Verification of Clinical Training for Examination Eligibility

Please check (✓) if the applicant completed clinical training as part of their academic program? _______

2. Directions: Please check (✓) by each area in which this applicant has obtained clinical training as part of their academic program. (NOTE: It is the applicant’s responsibility to ensure clinical training is documented in all FOUR areas as required for eligibility.)

Blood Banking (Immunohematology) _________  Microbiology _________

Chemistry _________  Hematology _________

LENGTH OF CLINICAL TRAINING PROGRAM (in months) ______________

TYPE OF DEGREE ______________

DATE OF COMPLETION ___________________________ (MONTH) (DAY) (YEAR)

This is to document that the above named student has successfully completed the current minimum academic requirements for the Board of Certification International Medical Laboratory Scientist examination as checked and listed above, and has completed or will complete a baccalaureate degree or equivalent by the examination date. I verify that the named student is enrolled in a Medical Laboratory clinical training program at the institution mentioned below and that this student will successfully complete the Medical Laboratory clinical training program prior to the examination date. I agree to notify the Board of Certification promptly if the student fails to complete any of the conditions stipulated above.

(Please Print) PROGRAM DIRECTOR’S NAME ____________________________________________

TITLE ___________________________ DATE ___________________________

PROGRAM DIRECTOR’S SIGNATURE ___________________________________________

NAME OF PROGRAM ___________________________________________________________

PROGRAM DIRECTOR’S EMAIL ADDRESS ___________________________________________

INSTITUTION ___________________________ INSTITUTION TELEPHONE NUMBER ___________________________

INSTITUTION ADDRESS _________________________________________________________

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. TRAINING DOCUMENTATION FORMS RECEIVED WITHOUT LETTERS OF AUTHENTICITY ARE UNACCEPTABLE. PLEASE MAIL OR EMAIL THESE FORMS TO ASCP INTERNATIONAL.

BOC 5/15