

**Only submit if program completion is being used in lieu of 1 year of experience.**

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

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

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

Successful completion of a NAACLS accredited MLS program, NAACLS or ABHES accredited MLT program, or a foreign medical laboratory science clinical training program within the last five years can be used in lieu of one year of full time acceptable clinical experience.

#### 1. PLEASE COMPLETE:

Institution Name	Institution Address
Type of Program (check the appropriate box below):	
<input type="checkbox"/> NAACLS Accredited MLS Program	Six Digit School Code _____
<input type="checkbox"/> NAACLS Accredited MLT Program	Six Digit School Code _____
<input type="checkbox"/> ABHES Accredited MLT Program	Six Digit School Code _____
<input type="checkbox"/> Foreign medical laboratory science clinical training program	

**BEGINNING DATE OF PROGRAM:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**COMPLETION DATE OF PROGRAM:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**2. DIRECTIONS:** Please check (✓) by each area in which this applicant has obtained clinical training as part of their medical laboratory training program. (NOTE: It is the applicant's responsibility to ensure clinical experience is documented in **ALL 6** areas as required for eligibility.)

<input type="checkbox"/> Blood Banking	<input type="checkbox"/> Microbiology
<input type="checkbox"/> Chemistry	<input type="checkbox"/> Immunology
<input type="checkbox"/> Hematology	<input type="checkbox"/> Urinalysis and Other Body Fluids

**3. BY SIGNING THIS FORM, I AS THE PROGRAM DIRECTOR, VERIFY THAT THIS APPLICANT HAS SUCCESSFULLY COMPLETED THE PROGRAM AS INDICATED ABOVE.**

(Please Print) Program Director Name & Credential(s)	Title
Program Director Signature	Date
Telephone Number	Email Address
City, State	Zip Code

**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.**

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