

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 IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* IN ORDER TO BE ACCEPTABLE)

SUBJECT: VERIFICATION OF EXPERIENCE FOR EXAMINATION ELIGIBILITY

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

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

Date experience **started** in Cytology: Month _____ Day _____ Year _____

Date experience **ended** in Cytology: Month _____ Day _____ Year _____

How many hours per week in Cytology? _____

2. BY SIGNING THIS FORM, I AS THE IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* VERIFY THAT THIS APPLICANT HAS PERFORMED SATISFACTORILY IN THE AREA OF CYTOLOGY.

| | |
|--|---------------|
| (Please Print) Immediate Supervisor or Laboratory Management* Name & Credential(s) | Title |
| Immediate Supervisor or Laboratory Management* Signature | Date |
| Telephone Number | Email Address |
| Institution | Zip Code |
| City, State | |

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* 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 IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT*.

**Management is defined as someone in a management role who can verify technical experience.*

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