

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 Cytometry examination. In order to establish this applicant's eligibility for certification, the following flow cytometry laboratory** experience information is necessary:

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

Date experience **started** in flow cytometry: Month _____ Day _____ Year _____
 Date experience **ended** in flow cytometry: Month _____ Day _____ Year _____
 How many hours per week in flow cytometry? _____

2. DIRECTIONS: Please review the experience of this applicant. A specialist in cytometry must demonstrate proficiency in moderate and high complexity testing. Please place an **X** by each procedure in the following three areas in which the applicant has adequate flow cytometry laboratory** experience under your supervision.

***A flow cytometry laboratory is defined as one capable of providing individuals with knowledge and practical experience in flow cytometry including sample processing, data acquisition, data analysis, quality assurance/control, instrument operation, and laboratory operations/management.*

A. Flow Cytometry Applications (NOTE: Experience is required in at least **1** of the 12 areas listed below.)

<input type="checkbox"/> Immunophenotyping (e.g., CD4, leukemia/lymphoma, transplant)	<input type="checkbox"/> Red blood cell analysis (e.g., PNH, fetal hemoglobin)	<input type="checkbox"/> Microorganism and/or microparticle analysis
<input type="checkbox"/> Cell sorting	<input type="checkbox"/> Progenitor cells	<input type="checkbox"/> Multiplex bead assays
<input type="checkbox"/> Cell cycle analysis / DNA ploidy	<input type="checkbox"/> Therapeutic drug monitoring	<input type="checkbox"/> Imaging cytometry
<input type="checkbox"/> Apoptosis	<input type="checkbox"/> Functional assays	<input type="checkbox"/> Rare event analysis

B. Cytometric Analysis (NOTE: Experience is required in at least **3** of the 5 areas listed below.)

<input type="checkbox"/> Specimen processing	<input type="checkbox"/> Instrument set-up	<input type="checkbox"/> Specimen analysis
<input type="checkbox"/> Data management	<input type="checkbox"/> Interpretation of results	

C. Quality Assurance (NOTE: Experience is required in at least **3** of the 6 areas listed below.)

<input type="checkbox"/> Specimen collection, processing, storage	<input type="checkbox"/> Reagent selection, preparation, storage, disposal
<input type="checkbox"/> Assay selection, validation, documentation	<input type="checkbox"/> Instrument operation and maintenance
<input type="checkbox"/> Quality control and proficiency testing	<input type="checkbox"/> Safety

3. BY SIGNING THIS FORM, I AS THE IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT* VERIFY THAT THIS APPLICANT HAS PERFORMED SATISFACTORILY IN THE CYTOMETRY AREAS CHECKED ON THIS FORM.

(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

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.