ASCP BOARD OF CERTIFICATION

QUALIFICATION IN APHERESIS
EXPERIENCE DOCUMENTATION FORM (Route 5)

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 U.S. Social Security # *(if applicable)* _____

PART II (MUST BE COMPLETED AND SIGNED BY THE RESPONSIBLE SUPERVISING PHYSICIAN IN ORDER TO BE ACCEPTABLE.)

SUBJECT: VERIFICATION OF EXPERIENCE FOR EXAMINATION ELIGIBILITY

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

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

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

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

   How many hours per week in Apheresis? _____

2. **DIRECTIONS:** Please review the experience of this applicant. Please place an **X** by each area in which this applicant has demonstrated proficiency under your supervision. Individuals certifying proficiency should have personally observed or reviewed the applicant's work. (NOTE: Experience is required in **ALL** of the areas listed below.)

   _____ Evaluating patients and/or donors for suitability to undergo apheresis procedures
   _____ Writing orders for apheresis procedures
   _____ Supervising apheresis procedures
   _____ Evaluating and managing adverse events during apheresis procedures

3. **BY SIGNING THIS FORM, I AS THE RESPONSIBLE SUPERVISING PHYSICIAN, VERIFY THAT THIS APPLICANT HAS PERFORMED SATISFACTORILY IN THE APHERESIS AREAS CHECKED ON THIS FORM.**

(Please Print) Responsible Supervising Physician's Name & Credentials(s) _____ Title _____

Responsible Supervising Physician's Signature _____ Date _____

Telephone Number _____ Email Address _____

Facility / Institution _____

Facility / Institution Address _____

BE SURE TO INCLUDE A LETTER OF AUTHENTICITY FROM YOUR RESPONSIBLE SUPERVISING PHYSICIAN 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 RESPONSIBLE SUPERVISING PHYSICIAN.

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