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 PROGRAM DIRECTOR IN ORDER TO BE ACCEPTABLE)

1. PLEASE COMPLETE:

Institution Name

School Code Number

Date Applicant Completed the NAACLS Program: Month _____   Day _____   Year _____

2. BY SIGNING THIS FORM, I AS THE PROGRAM DIRECTOR VERIFY THAT THIS APPLICANT HAS SUCCESSFULLY COMPLETED A NAACLS ACCREDITED MEDICAL LABORATORY SCIENCE PROGRAM.

(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 for submission instructions.