ASCP BOARD OF CERTIFICATION

# MEDICAL LABORATORY SCIENTIST

## MLT or MLS Program Completion (Routes 2 and 4)

Not to be used for Route 1 applications

**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):

_____ NAACLS Accredited MLS Program Six Digit School Code _____

_____ NAACLS Accredited MLT Program Six Digit School Code _____

_____ ABHES Accredited MLT Program Six Digit School Code _____

_____ 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.)

_____ Blood Banking _____ Microbiology

_____ Chemistry _____ Immunology

_____ Hematology _____ 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 for submission instructions.