AMERICAN CERTIFICATION AGENCY
FOR HEALTHCARE PROFESSIONALS

P.O. Box 58
Osceola, IN 46561
TEL: (574) 254-1307
FAX: (574) 254-1307

Application for Certification as a
CERTIFIED PATIENT CARE TECH INSTRUCTOR - CPCI (ACA)

Print or type your name exactly as you want it to be on your certificate.

Last name **First name** **Middle initial/name**

Information and Instructions to Applicant

1. Please type or print all information **except** where signatures are required.

2. Please check the eligibility requirements for certification approval on the next page.

3. Before submitting this application, make sure you have provided the following:

   _____ $150.00 application fee (must accompany the application or it will not be processed).
   _____ Proof of certification or state license.
   _____ Proof of graduation from phlebotomy school, college or equivalent training program.
   _____ Proof of current CPR certification.
   _____ Current resume.
   _____ One written letter of reference attesting to experience in the healthcare environment, teaching and training of personnel in phlebotomy, ECG and patient care.
   _____ Proof of at least 10 hours of medical continuing education during the past year.
   _____ A detailed syllabus or course outline.
   _____ Completed application signed and dated by applicant and deans and/ or supervisor.

4. All applications are subject to content verification and approval.

5. Ineligible applicants will be refunded the application fee minus a $50 processing fee.

6. Upon approval applicant will receive a certificate as a Certified Patient Care Tech Instructor.

7. Instructor certification must be renewed annually by providing proof of 10 hours of medical continuing education and submitting a $50 recertification fee.

ELIGIBILITY REQUIREMENTS FOR INSTRUCTOR APPROVAL

1. Applicant shall be a graduate of an accredited high school or acceptable equivalent.

2. Applicant must meet the following requirements:

   A. ☐ Registered or certified laboratory technologist/scientist/technician, certified phlebotomist, certified medical assistant or licensed/registered LPN/RN.

   B. ☐ Current CPR certification.

   C. ☐ A minimum of three years work experience in the healthcare environment with documented experience in performing phlebotomy, ECG and patient care.

   D. ☐ A minimum of one year documented teaching experience in all above areas.

Part I. PERSONAL INFORMATION

Full Name_____ **Social Security Number** xxx / xx /_____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone Number (_____**)**_____ **Work Phone Number (**_____**)**_____

Email Address _____

Part II. EDUCATION AND TRAINING

A. Secondary

Senior High School_____ **Dates attended**_____

Address_____ **Date graduated**_____

GED_____ **Date**_____ **City/State**_____

B. College or University

Name/Complete Address	Dates	Hrs. completed	Degree

C. Healthcare and/or Training

The applicant's final transcript/certificate(s) of completion must be provided.

1. **Applicant** _____ **Date of Birth** _____

School _____

Program Name _____ **Tel no:** _____

School Address _____

Course dates: From ____/____/____ **to** ____/____/____

2. **School Name** _____

Program Name _____ **Tel no:** _____

School Address _____

Course dates: From ____/____/____ **to** ____/____/____

PART III. EMPLOYMENT EXPERIENCE

Approved Healthcare Experience

All approved healthcare experience credited toward certification must be earned in an approved healthcare facility such as a hospital, physician office laboratory, independent laboratory, HMO, group practice, etc.

1. **Facility** _____ **Employment dates (mo. & yr.)**

Address:
_____ **From** ____/____ **to** ____/____

Position Held **Supervisor's Name** **Telephone number**

_____

2. **Facility** _____ **Employment dates (mo. & yr.)**

Address:
_____ **From** ____/____ **to** ____/____

Position Held **Supervisor's Name** **Telephone number**

_____

Part IV. **PATIENT CARE TECHNICIAN COURSE CONTENT**

Name of facility where training is to be held _____

Address & Telephone # _____

Title of Course _____

# of classes per year _____ **# of students per class** _____

Total length of course _____**Hrs;** **Lecture Time** _____**Hrs;** **Student Lab Time**_____**Hrs**

Clinical Experience Time _____ **Hrs**

Names and addresses of primary clinical experience facilities:

1. _____

2. _____

3. _____

4. _____

Person responsible for monitoring clinical experience _____

Address & Telephone # _____

PART V. **RECOMMENDATION FOR CERTIFICATION**

Please have supervisor, manager or dean sign this recommendation for certification.

Signature_____ **Date**_____

Title_____ **Address** _____

PART VI. **AGREEMENT**

I hereby give my authorization to the American Certification Agency for Healthcare Professionals to request necessary information from individuals, institutions, and/or organizations named herein to validate information for certification. I certify that the information given herein is true and correct, to my knowledge and belief, and realize that certification is subject to revocation for misrepresentation. If accepted as a certificant, I agree to uphold and abide by the Standards of Practice and Bylaws of the American Certification Agency for Healthcare Professionals.

Applicant's Signature_____ **Date**_____

Do not write in space below

Date application received____/____/____ Date completed____/____/____ Approved by_____

Application rejected by_____ Reason_____ Date notified____/____/____

GRANTED CERTIFICATE #_____ Issue Date____/____/____

RECERTIFICATION DATES:_____