AMERICAN CERTIFICATION AGENCY
FOR HEALTHCARE PROFESSIONALS

P.O. Box 58
Osceola, IN 46561
TEL: (574) 277-4538
FAX: (574) 277-4624

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 necessary deans and/ or supervisors.

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.

   4. ❑ A minimum of one year documented teaching experience.

Part I. **PERSONAL INFORMATION**

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

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

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

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 must be provided.

1. Applicant Name
School Name
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: