

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 PHLEBOTOMY INSTRUCTOR - CPI (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) **Copy of a PICTURE ID.**
 - _____ 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.
 - _____ 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 Phlebotomy Technician Instructor.
7. Instructor certification must be renewed annually by providing proof of 10 hours of medical continuing education and submitting a \$80. 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 or equivalent.
 - B. Current CPR certification.
 - C. A minimum of three years work experience in the healthcare environment with documented experience in performing phlebotomy.
 - D. A minimum of one year documented formal (both lectures and clinical skills) phlebotomy teaching experience-.

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 Phlebotomy Training

The applicant's final transcript and/or certificate must be provided.

1. Applicant Name _____ Birthdate _____

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 Phlebotomy Experience

All approved phlebotomy 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.

PHLEBOTOMY 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. _____

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: _____
