

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 TECHNICIAN - CPT(ACA)

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

Last name

First name

Middle initial or 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 on the next page.
3. Before submitting this application, make sure you have provided the following:
 - _____ \$100.00 application fee (must accompany the application); **Copy of a PICTURE ID.**
 - _____ Proof of high school graduation or equivalent
 - _____ If applicable, official final transcript stating graduation from phlebotomy school, college or training program
 - _____ If applicable, copy of state license or other phlebotomy certification
 - _____ Application signed and dated by applicant and necessary instructors and supervisors
4. Application must be completed, signed and received at least 15 days before the scheduled examination date.
5. All applications are subject to content verification and approval.
6. Ineligible applicants will be refunded the examination fee minus a \$35.00 processing fee.
7. No refunds will be made for no-shows on the exam date.
8. You will receive notification upon approval of this application, informed of scheduled examination site, receive study guide and content outline.

ELIGIBILITY REQUIREMENTS FOR CERTIFICATION

1. Applicant shall be a graduate of an accredited high school or acceptable equivalent.
2. Applicant must meet one of the following requirements (check one box):
 - A. Completed at least one year of work experience using phlebotomy skills.
 - B. Successful completion of a formal program (e.g. phlebotomy, laboratory assistant, medical assistant, EMT, nursing, etc.) which includes didactic instruction and a minimum of 100 clinical hours. Must show documentation of at least 100 successful venipunctures and 10 skin punctures.
 - C. Have a current, valid certification obtained by an examination from another certification agency or society approved by ACA. These applicants will be considered for ACA certification without taking another exam. Recertification requirements must be met.
3. All applicants applying under 2 A. and 2 B. **must** take and **pass** the ACA examination for Certified Phlebotomy Technician (CPT).

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 _____

G.E.D. _____ Date _____ City/State _____

B. College or University

Name/Complete Address	Dates	Hrs. completed	Degree
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Phlebotomy Training

If applicant is currently in school or training program, this section must be completed by a proper school official to verify training and successful completion of the course. Proof of program completion must be provided.

Applicant Name _____ Birthdate _____

School Name _____

Program Name _____ Tel no: _____

School Address _____

Course dates: From _____ / _____ / _____ to _____ / _____ / _____

Applicant has completed 100 successful venipunctures Yes No

Applicant has completed 10 successful skin (dermal) punctures Yes No

I hereby certify that the applicant named above did (or will) satisfactorily complete the entire formal program which included didactic instruction and a minimum of 100 hours of clinical experience. Skin punctures waived if not available. I recommend this applicant as a qualified candidate for certification as a Certified Phlebotomy Technician

Official Signature _____ Date _____

Title/Position _____

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 _____
3. Facility _____ Employment dates (mo. & yr.) _____
Address: _____ From _____ / _____ to _____ / _____
Position Held _____ Supervisor's Name _____ Telephone number _____

PART IV. RECOMMENDATION FOR CERTIFICATION

If applicant is currently employed, please have supervisor or manager sign this recommendation for certification.

Signature/Title _____ Date _____

Address

_____ Street City State Zipcode

PART V. OPTIONAL SCORE RELEASE

Some educational institutions and/or state licensure boards request applicants' examination results. To grant permission for your results to be eligible for release if requested, sign the release authorization below. Signing this release is VOLUNTARY and will not effect the outcome of your examination in any way. If you DO NOT want your results released, DO NOT SIGN THE AUTHORIZATION. I hereby authorize the American Certification Agency for Healthcare Professionals to release my examination scores:

Applicant's Signature _____ Date _____

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 ____ / ____ / ____

Exam Date	Test Series	Exam Site	Proctor	Exam Score	Fee Paid

Birth date _____ Social Security Number _____

GRANTED CERTIFICATE # _____ ISSUE DATE _____

RECERT DATES _____

