

LABORATORY PERSONNEL QUALIFICATION APPRAISAL

1. NAME (Last, First, Middle):
2. PRESENT EMPLOYER (Name and Address):
3. MAIDEN NAME IF MARRIED
4. EMPLOYMENT WORK ARRANGEMENTS:
5. MAILING ADDRESS:
6. EMPLOYER'S IDENTIFICATION NUMBER(S):

7. POSITION(S) CURRENTLY HELD IN LABORATORY (v):
Technical Supervisor only. Check (v) the following in which you presently function.
Director, General Supervisor, Cytotechnologist Supervisor, Technical Supervisor, Clinical Consultant, Technical Consultant, Technologist, Technician, Microbiology, Hematology, Histocompatibility, Immunology, Immunohematology, Tissue Pathology, Chemistry, Cyto genetics, Cytology

8. EDUCATION: a. High School Graduate or equivalent Yes No b. College, University, or other school(s) attended.

Table with 5 columns: NAME AND ADDRESS OF INSTITUTION, ATTENDED (FROM MO, YR, TO MO, YR), MAJOR, DEGREE, DIPLOMA, OR CERTIFICATE (INCLUDE MONTH AND YEAR CONFERRED)

(Verification of Degree, Diploma, Certificate and/or transcript of grades may be requested.)

9. CLINICAL LABORATORY TRAINING (v) (each training period fulfilling a Degree, Diploma, or Certificate requirement listed in item 8.)

Table with 5 columns: NAME AND ADDRESS OF INSTITUTION, ATTENDED (FROM MO, YR, TO MO, YR), PROGRAM TITLE, DEGREE, DIPLOMA, OR CERTIFICATE (INCLUDE MONTH AND YEAR CONFERRED)

(Verification of Degree, Diploma, Certificate may be requested.)

10. LICENSE, CERTIFICATION OR REGISTRATION

Table with 5 columns: NAME OF GRANTING AGENCY, LICENSURE/CERTIFICATION OR REGISTRATION TITLE, GRANTED (MO, YR), LIC. CERT. OR REG. #, MD/DO (v) IF ONLY BOARD ELIGIBLE

(Verification of Board Eligibility may be requested)

11. PROFICIENCY EXAMINATIONS - DEPT. OF HEALTH AND HUMAN SERVICES

Table with 4 columns: (v) APPROPRIATE EXAM TITLE(S) BELOW, PASSED (MO, YR), IDENTIFICATION #, DIRECTORS CHECK (v) SECTIONS PASSED (General, Hematology, Microbiology, Chemistry, Serology, ABO & Rh typings)

(Verification of Passing Examination may be requested.)

12. CLINICAL LABORATORY EXPERIENCE NAME AND ADDRESS OF LABORATORY OR INSTITUTION - BEGIN WITH EARLIEST EMPLOYMENT SINCE EDUCATION/TRAINING AND CONTINUE THROUGH PRESENT EMPLOYMENT. ANY GAPS IN EMPLOYMENT WILL BE ASSUMED TO BE NON-CLINICAL LABORATORY WORK PERIODS.	PERIOD EMPLOYED				POSITION(S) HELD	EXPERIENCE IN THE FOLLOWING:										
	FROM		TO			MICROBIOLOGY	IMMUNOLOGY	CHEMISTRY	HEMATOLOGY	IMMUNOHEMATOLOGY	CYTOLOGY	TISSUE PATHOLOGY	ORAL PATHOLOGY	RADIOBIOASSAY	HISTOCOMPATIBILITY	OTHER
	MO	YR	MO	YR												

\*Indicate position(s) as shown in item 7.

13. REMARKS (Add information pertinent to your education, training, employment, etc., not included above)

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CERTIFICATION: I CERTIFY that all of the statements made in this form are true, complete and correct to the best of my knowledge and belief and are made in good faith.

14. Signature of applicant (sign in ink):

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Date:

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CERTIFICATION: I have reviewed the entries made herein and to the best of my knowledge they are true, complete and correct.

15. Signature of Current Laboratory Director (sign in ink):

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Date:

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16. STATE AGENCY EVALUATION (Do not write below this line.)

- a. Meets State Licensure Requirements (if applicable) as:
- Director     Technical Consultant     Technical Supervisor     Technologist
  - Technician     Technician Trainee     Cytotechnologist     Supervisory Technologist

- b. Meets Federal Requirements as:(Circle appropriate paragraph number(s). Show all positions in which individual functions and qualifies in laboratory.
- 493.1415(b) 1 2 3 4 5 6     493.1433(b) 1 2 3 4 5 6
  - 493.1427(b) 1 2 3 4 5     493.1437(b) 1 2 3
  - 493.1427(b) 5     493.1441(b) 1 2 3 4 5
  - 493.1421 a b c d e f g h i j k l m n o p q r s t                       493.1402

c. Does not qualify as \_\_\_\_\_. Explain in remarks position(s) in which individual function or proposes to, but does not qualify

17. REVIEWER REMARKS:

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18. STATE AGENCY REVIEWER:

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19. DATE:

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