**NCSLPH Workshop Application**

Date Application Received:

Accept 

Cancelled 

Reject 

NS 

**State Lab Use Only**

**\*\*Please complete a separate application for each applicant and for each workshop.\*\***

**Name of Applicant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Please* ***PRINT*** *full name* ***LEGIBLY*** *for continuing education certificate*)

**Workshop Title:** *(See NCSLPH* *website)*

**Date of Workshop:** *(See NCSLPH website)*

\*\*Note: Refer to “Training Workshops” on NCSLPH website for descriptions, dates, and deadlines. \*\*

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR CLINICAL WORKSHOPS ONLY** | | | |
| **Certified Phlebotomist** | | * Yes  No **Date Certified**: / | |
|  | **If answered “NO” above, one of the following pre-requisites must be met to attend Phlebotomy Refresher and Critical Thinking Workshop:**   1. Currently performing phlebotomy: Supervisor/Manager name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Proof of phlebotomy training within the last 5 years: Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Completion of Phlebotomy and Bloodborne Pathogens Training through DPH, Communicable Disease Branch within the last 5 years. Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Certified Medical Assistant: Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. Nurse, MD, PA, NP, EMT, or Paramedic: Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Admittance to the workshop accepted at the discretion of the workshop director.** | |  |

Organization/Facility:

Street or Box Number:

City State Zip Courier#

**Phone #** (work) :( ) **Ext**. **Fax** ( )

***(Please ensure the e-mail addresses below are accurate and legible.)***

Supervisor E-Mail address

Applicant E-Mail Address

Certification/Licensure

Clinical: MT/MLT RN/LPN/FNP MOA PBT

Chemist Lab Tech Other

**Job Duties** (as related to the workshop applied for)

Signature of Applicant Signature of Applicant's Supervisor

Circumstances may limit acceptance **MAIL OR FAX COMPLETED APPLICATION AND CHECKS TO:**

to one person per lab. If two or more Laboratory Improvement Unit

apply, Supervisor must indicate PO Box 28047

1st, 2nd, etc. choice for Raleigh, NC 27611-8047

acceptance PH: 919-733-7186 FAX: 919-715-9243