

**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 PHLEBOTOMY INSTRUCTOR -CPCI (ACA)**

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

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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.
  - 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 \$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.
  - D. 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 (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Part II.  
EDUCATION AND TRAINING

Secondary Senior High School \_\_\_\_\_

Dates attended \_\_\_\_\_

Address \_\_\_\_\_

Date graduated \_\_\_\_\_

GED \_\_\_\_\_ Date \_\_\_\_\_ City/State \_\_\_\_\_

College or University

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

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.

Facility \_\_\_\_\_

Employment dates (mo. & yr.) \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Position Held \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

Telephone number \_\_\_\_\_

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: \_\_\_\_\_