

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 PATIENT CARE TECH INSTRUCTOR - CPCI (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 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, ECG and patient care.
 - _____ 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 deans and/ or supervisor.
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 Patient Care Tech 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, ECG and patient care.
 - D. ☐ A minimum of one year documented teaching experience in all above areas.

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
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C. Healthcare and/or Training

The applicant's final transcript/certificate(s) of completion must be provided.

1. Applicant _____ Date of Birth _____
School _____
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 Healthcare Experience

All approved healthcare 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.**PATIENT CARE TECHNICIAN 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. _____
4. _____

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: _____

