**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.

1. Ineligible applicants will be refunded the application fee minus a $50 processing fee.
2. Upon approval applicant will receive a certificate as a Certified Patient Care Tech Instructor.
3. 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:

1. Registered or certified laboratory technologist/scientist/technician, certified phlebotomist, certified medical assistant or licensed/registered LPN/RN.
2. Current CPR certification.
3. A minimum of three years work experience in the healthcare environment with documented experience in performing phlebotomy, ECG and patient care.
4. 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**

**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: