

## SCHOOL OF CLINICAL SCIENCES

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## PART I (To be completed by Applicant)

## MEDICAL LABORATORY SCIENTIST ATTESTATION TASK LIST

E-mail Address  PART II (MUST be completed and signed by the immediate supervisor or laboratory management** in order to be acceptable) In order to verify that the applicant has sufficient experience in the area(s), please indicate how you assessed the applicant's proficiency in all tasks below according to the following codes: O= the applicant observed the task, P= the applicant performed the task, V=applicant verbalized the task theory/steps, W=applicant passes a written exam for the task	Student's Name		Last Four Digits of Student's Social Security #
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Quality assurance processing  Routine coagulation (e.g. PT, APTT) Problem solving/troubleshooting			
Routine coagulation (e.g. PT, APTT) Problem solving/troubleshooting			

PAR	RT III By signing this form, I as the immediate supervisor or labora	tory management**
	Verify clinical laboratory has the following accreditation:  ☐ CMS CLIA certificate of registration, compliance, accreditation; OR Accreditation; OR COLA Accreditation; OR Accreditation under ISO ☐ Other:	
2) <b>[</b>	☐ verify that this employee has a minimum of two years full-time work satisfactorily in the areas checked on this form within the last four years Date: End Date:	ears.
(	OR	
ſ	☐ verify that this employee <u>does not</u> have a minimum of two years fullenter employee performing satisfactorily in the areas checked on this form Hire Date: End Date:	1.
	AND	
I	□ verify if this employee has remaining <u>unmet</u> areas in Part II of this for practicum for the remaining unmet areas in accordance with accred MLS curriculum.	
(	OR	
•	□ verify if this employee has remaining unmet areas in Part II of this for a practicum for the remaining unmet areas in accordance with accreding MLS curriculum. If the employer is unable to provide a practicular areas, please indicate with the word "NO" next to the task in Parameters.	ditation requirements by the end of the n for any of the unmet required
PRIN	ITED NAME OF IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT**	AREA CODE/TELEPHONE #
SIGN	NATURE OF IMMEDIATE SUPERVISOR OR LABORATORY MANAGEMENT**	DATE
INST	TITUTION	
CITY	STATE	ZIP
E-M	AIL ADDRESS	
**N	lanagement is defined as someone in a management role who can verify	r technical experience.
	RT IV By signing this form, I as the Student	
	verify I have not performed all of the required tasks on this form and I accordance with accreditation requirements	agree to complete a practicum in
STU	DENT'S SIGNATURE	DATE