

Name : _____ Program Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Date Attended: _____ to _____ Phone: (____) _____

Date of Graduation: _____ Degree Received: _____ Degree Major: _____

3

Name : _____ Program Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Date Attended: _____ to _____ Phone: (____) _____

Date of Graduation: _____ Degree Received: _____ Degree Major: _____

4

Name : _____ Program Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Date Attended: _____ to _____ Phone: (____) _____

Date of Graduation: _____ Degree Received: _____ Degree Major: _____

SUBMIT A PHOTO-COPY OF ALL COLLEGE DIPLOMAS. If a diploma is not available, please submit an official copy of each transcript. (The Major For Which The Degree Was Awarded Must Be Indicated). If the applicant has not completed the requirements for graduation, he/she must submit notice to the CLASCB of completion within the stipulated time frame outlined in the accompanying information in section "Deadline For Meeting Eligibility". which is verified by the school attended or program director.

(Section 3 of 6)

**Work Experience in Medical Technology, Nuclear Medicine,
Radioassay Technology or Laboratory Technology**

#1 (Most Recent)

Institution Name: _____ Dates Employed: From _____ To _____

Total Months Employed: _____ Employment Title: _____

Type Of Work: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone: (____) _____

Supervisor: _____

#2

Institution Name: _____ Dates Employed: From _____ To _____

Total Months Employed: _____ Employment Title: _____

Type Of Work: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Supervisor: _____

#3

Institution Name: _____ Dates Employed: From _____ To _____

Total Months Employed: _____ Employment Title: _____

Type Of Work: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Supervisor: _____

#4

Institution Name: _____ Dates Employed: From _____ To _____

Total Months Employed: _____ Employment Title: _____

Type Of Work: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Supervisor: _____

(Section 4 of 6)

If you are submitting an application for the speciality of Radioassay, indicate the qualifying category that applies to you:

_____ Holding a bachelor's degree or higher from an accredited college or university in a Nuclear Medicine Technology or Medical Technology Program approved by the Committee on Allied Health Education and Accreditation OR

_____ Holding a bachelor's degree or higher in one of the chemical, physical or biological sciences or a bachelor's degree in medical technology from a accredited college or university which includes a minimum of 8 semester hours in chemistry and an additional minimum 8 semester hours in the biological sciences AND having a minimum of one year (2000 hours) work experience in Radioassay Technology OR

_____ Having successfully completed 2 years of academic study with a minimum of 60 semester hours or equivalent in an accredited college or university in a Nuclear Medicine Technology or Medical Technology Program approved by the Committee on Allied Health Education and

Accreditation OR

_____ Having successfully completed 60 semester hours or equivalent of academic study in an accredited college or university with at least 8 of the 60 semester hours in Chemistry and 8 of the 60 semester hours in the Biological sciences and at least 1 year work experience (2000 hours) in Radioassay Technology.

Note:

- On the job training (OJT) and education will not be accepted in lieu of formal education.

For the speciality of Radioassay through examination waiver:

_____ Holds a current United States or Canadian license in the specialty of Radioassay or a speciality, category, or discipline permitting the process of radioassay upon human and or animal body specimens which acknowledges competency, education and experience AND meets the requirements as stipulated in the requirement section for examination of the speciality. INCLUDE A COPY OF YOUR CURRENT STATE LICENSE Applications with non United States or Canadian credentials will be evaluated through an agency prior to the Certification Board review as described in the section of this document entitled "Foreign Credentials".

(Section 5 of 6)

If you are submitting an application for the speciality of Ligand Assay, indicate the qualifying category that applies to you:

_____ Holding a bachelor's degree or higher from an accredited college or university in a Medical Technology Program or a Nuclear Medicine Technology Program approved by the Committee on Allied Health Education and Accreditation OR

_____ Holding a bachelor's degree or higher in one of the chemical, physical or biological sciences from a accredited college or university which includes a minimum of 8 semester hours in chemistry and an additional minimum 8 semester hours in the biological sciences AND having a minimum of one year (2000 hours) technological work experience in Radioassay or Laboratory Technology

Note:

- On the job training (OJT) and education will not be accepted in lieu of formal education.
- Examination waiver is not available for the speciality of Ligand Assay.
- Applications with non United States or Canadian credentials will be evaluated through an agency prior to the Certification Board review as described in the section of this document entitled "Foreign Credentials".

(Section 6 of 6)

List the institution(s) that you wish the results of the examination and/or Certification through examination waiver for CLASCB to be sent. An administrative fee will be charged for mailings beyond one institution.

Name and / or Office: _____ Institution Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Name and / or Office: _____ Institution Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Name and / or Office: _____ Institution Name: _____

Address: _____ City: _____ State: ___ Zip: _____

I hereby instruct and give permission for the Clinical Ligand Assay Certification Board (CLASCB) to give the results of the Certification Board Examination or Certification through examination waiver to those individuals or organizations listed above. I hold harmless the CLASCB if examination results and or correspondence is unintentionally or mistakenly sent to a different organization or person than listed above. I hereby make application to the Clinical Ligand Assay Society Certification Board (CLASCB) for examination and or Certification through examination waiver and understand and agree to be bound by all of the rules and regulations of the CLASCB. I understand and agree that this application and all statements letters and credentials submitted become the property of the CLASCB.

Applicant's Full Signature: _____ Date: _____

Return application and fee to: CLAS Certification Board, 3139 South Wayne Road, Wayne, Michigan 48184