Phlebotomy Technician Certification
Critical Skill Competency Documentation
2025 (All states except Louisiana)

Instructions Page for Verifiers

Thank you for assisting this applicant in completing the form required for the NCPT certification. This form is required to verify qualifying phlebotomy training, competency, and successful completion of live blood collections performed during supervised training.

Instructions for Completing This Form:

1. Documentation Requirements

- Complete all fields clearly and legibly
- Facility-specific verification only (no cross-facility attestations)
- One (1) verifier per form
- Simulated/mannequin experiences do not qualify for competency verification.
- Forms that appear altered or falsified will not be accepted and may result in denial of eligibility.

2. Who Should Complete Which Parts

- **Applicant:** Section A (Applicant Information)
- **Verifier:** Sections B-E
  - Must provide a work email address (facility domain) and a direct business phone number.
    **Personal email accounts or personal phone numbers will not be accepted*
  - The verifier must be currently employed at the facility where the applicant completed supervised live blood collections and must have firsthand knowledge of the applicant's performance.

3. Educational Pathway

- **What is verified:** Competency and successful performance of required phlebotomy skills and live blood collections.
- Training must include supervised live blood collections. Simulated, mannequin, or observational-only experiences do not qualify.
- **NCCT-Authorized Programs**: Forms may be completed by the Program Director, Instructor, Clinical Coordinator, Externship Coordinator, Preceptor, Program Manager, or other supervisor with direct knowledge of the applicant's hands-on training and skill performance.
- **Non-NCCT-Authorized Programs**: Forms must be completed by a physician (MD/DO), PA, NP, RN, laboratory manager, phlebotomy supervisor, preceptor, or other qualified supervisor with direct knowledge of the applicant's hands-on training and skill performance.
- **Training Dates**: Provide dates of supervised hands-on training.

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Section A: To Be Completed by the Applicant
Please enter your full legal name as it appears on a government-issued ID (e.g., driver's license, passport).

Legal Name of Applicant _____ NCCT User ID # _____

Section B: To Be Completed by Verifier
Important: Before completing this section, **please read the Instruction Page (Page 1).** The verifier must have direct knowledge of the applicant's hands-on phlebotomy training and skill performance. Each facility may only verify training performed under its supervision at that facility.

Section C: Critical Skill Performance Competency
Verifier must only initial skills they directly observed or can verify through official training records as having been performed safely and competently through supervised live blood collections.

Critical Skill Performance Competency	***Initials***
Venipuncture *(performance of minimum of 50 venipuncture procedures)*	
Capillary puncture *(performance of a minimum of 10 capillary puncture procedures)*	

NOTE: Simulated experiences, mannequin practice, or classroom demonstrations do not meet qualification criteria.

Additional comments *(optional)*: _____

Section D: Clinical Training Dates

Applicant's dates of supervised hands-on training at my facility: From __/__/_____ through __/__/_____

Section E: Verification Statement

By signing this form, I attest that the applicant named above has consistently and accurately demonstrated the required critical skills within the scope of a Phlebotomist, as defined under applicable state law, through supervised hands-on phlebotomy training under my supervision or through official training records maintained by the program/facility. I further attest that the information provided is complete, true, and correct to the best of my knowledge.

I acknowledge that falsifying, omitting, or misrepresenting information on this form may result in denial of the applicant's eligibility, cancellation of examination results, or revocation of certification. I understand that my role as verifier requires that I am currently employed at the facility listed below and had direct supervisory responsibility over the applicant during the period verified. I also understand and agree that NCCT staff may contact me directly to verify the accuracy of this attestation.

Today's Date: MM/DD/YYYY _____

Supervisor/Verifier Signature _____

Supervisor/Verifier Printed Name _____

Supervisor/Verifier Job Title _____

Training Facility/Organization Name _____

Training Facility/Organization Address _____City, State _____ Zip _____

Business Phone _____ Business Email _____

**Personal email accounts or personal phone numbers will not be accepted*