National Center for Competency Testing

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Office Hours: M-F 7:30am - 7:00pm CST
Saturday 9:00am - 3:00pm CST

Phlebotomy Technician Certification Critical Skill Competency

(Official Documentation of Route 1a, Route 1b, and Route 3)

Rev: September 2016

To be completed by the applicant: (Please return this form to NCCT with your application.)

Name of applicant _____

Today's Date (MM/DD/YYYY) _____

To be completed by the applicant's direct patient care supervisor: (School Official, Licensed Physician, Primary Care Provider, Laboratory Manager (CLS, MLS, MT).

The person named above is applying for certification in their role as a Phlebotomy Technician. In order to determine the eligibility of the applicant we require documentation of proficiency in several critical skill areas as identified below. Each employer may only verify work experience performed at their own facility.

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (safe, consistent, and successful) in performing each of the critical skill areas as identified below. (Note: Actual patient care verification in an ambulatory care, medical office, or clinic environment is required – ***simulated clinical experiences or mannequin punctures do not meet qualification criteria***). Please verify competency by providing your initials next to each critical skill that you are attesting to, within the Phlebotomy Technician scope of practice/employment, according to individual state laws. Your signature and legible information are required for valid completion of this form.

Critical Skill Performance Competency	***Initials***
Venipuncture *(performance of a minimum of 25 venipuncture procedures)*	
Capillary puncture *(performance of a minimum of 5 capillary puncture procedures)*	
Additional comments *(optional):*	

The applicant performed these critical skills from _____ (*month*) /_____ (*year*) through _____ (*month*) /_____ (*year*).

Today's Date: MM/DD/YYYY _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Signature _____

Supervisor/Verifier Printed Name _____

Company Name _____

Supervisor's Title _____

Address _____ City, State, Zip _____

Phone _____ Email _____