National Center for Competency Testing

7007 College Blvd., Ste. 385, Overland Park, KS 66211
Phone 800.875.4404; Fax 913.498.1243
Office Hours: M-F 7:30am - 7:00pm CST
Saturday 9:00am - 3:00pm CST

Tech in Surgery - Certified (NCCT) Qualification by Experience

(Official Documentation of Route 2)

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: (Licensed Physician, Primary Care Provider, and/or RN)

The person named above is applying for certification in the field of Surgical Technology. In lieu of successful completion of an eligible Surgical Technology program, the applicant is qualifying through work experience (NCCT Route 2 - Qualification by Experience). As such, the applicant must have documentation reflecting a minimum of three (3) years full-time work experience, within the past five (5) years, including performance in each of the critical skills for Surgical Technologists. 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 the performance of job tasks as a Surgical Technologist, as documented in the cases listed below. Your signature and legible identification/contact information are required for valid completion of the form. NCCT reserves the right to request case logs if required to support critical skill competencies. Please DO NOT submit case logs unless requested.

Critical Skill Performance Competency *The majority of cases in each category must be completed as 1st scrub. Please list the number of cases in the column.*	***1st Scrub***	***2nd Scrub***
Minimum of 50 scrubs in general surgeries; **and a**		
Minimum of 20 scrubs in orthopedic surgeries; **and a**		
Minimum of 55 scrubs in at least two (2) of the following areas: *(you are allowed to select the two (2) areas)*		
Gynecology		
Genitourinary		
Cardiovascular		
Neurosurgery		
Obstetrics		
Thoracic		
Peripheral Vascular		
Ophthalmology		
Otorhinolaryngology		
Plastic/Reconstructive		
Other *(please specify)*		
TOTALS		

Note: *This page may be photocopied if more than one employer will be verifying cases.*

The applicant's employment dates from _____ / _____ through _____ / _____ .
month *year* *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 _____