INITIAL and RENEWAL APPLICATION
for
CLINICAL LABORATORY PERSONNEL TRAINING PROGRAM

Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257
(850) 245-4355
http://www.floridasclinicallabs.gov/

Please read the following instructions before completing the application:

1. Attach a certified check or money order to the application payable to the Department of Health. **Do not send cash.**
2. All training programs (universities, community colleges, vocational technical schools, hospitals or laboratory based) for laboratory personnel should complete this application.
3. All programs must submit supporting documents (except nationally accredited programs).

COMPLETING THE APPLICATION:

INITIAL Application and Licensure Fees:
Initial Application Fee - $200.00 (non-refundable)
Initial Licensure Fee - $200.00
Total: $400.00

RENEWAL Application and Licensure Fees:
Renewal Licensure Fee - $300.00
Total: $300.00

Please submit the fees (by money order or cashier's check), application, and supporting documentation to the following address:

Board of Clinical Laboratory Personnel
Post Office Box 6330
Tallahassee, FL 32314-6330

If you have any additional documents to submit after your application has been mailed, please send to:
(Supporting documents/correspondence with NO fees)

Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

***As a reminder to all applicants, please note that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.**

INITIAL and RENEWAL APPLICATION INSTRUCTIONS/CHECKLIST
for
CLINICAL LABORATORY PERSONNEL TRAINING PROGRAM

(Please refer to **Rule Chapter 64B3-9, F.A.C.**) - Fees
(Please refer to **Rule Chapter 64B3-3, F.A.C.**) - Approval of Clinical Laboratory Personnel Training Programs

1. __________**Submit appropriate application and licensure fees**
   Initial Fees - $400.00
   Renewal Fees - $300.00

2. __________**Personnel/Instructors Roster (include FL license number)**
   Attach roster –
   - list all laboratory personnel including the level of licensure and license number;
     and
   - Instructors shall teach only in areas licensed as a technologist, supervisor and director; or 3 years of experience in clinical laboratory science education.

3. __________**Student Enrollment Roster**
   Attach roster –
   - All trainee names shall be reported to the board upon acceptance into the clinical laboratory personnel training program. Please include program start date and anticipated graduation date.

4. __________**Accreditation Verification (if accredited by NAACLS, CAAHEP or ABHES)**

   OR

   Self-Study (College, University, Vo-Tech or Hospital/Lab not accredited by NAACLS, CAAHEP or ABHES)
   Submit self- study document at the time of the initial application and shall update within 6 months of any major changes in curriculum, sponsorship, instructors, student enrollment, or clinical affiliates.

5. __________**Training – length of program**
   (List the number of hours students spend in class and in the laboratory. Specify the approximate weeks per year or percent of time per year spent in practical training and in lecture/didactic work. Attach the last CAP, JC, or state survey of the laboratory, if this is a laboratory-based program regardless of national accreditation.)

6. __________**Program Director (include resume)**
   Program shall have a director who holds national certification listed in subsections 64B3-5.007(2) and (4), F.A.C.,
   and:
   - holds a doctoral or master's degree in a chemical, biological or clinical laboratory science and 3 years of experience in clinical laboratory science education;
     or
   - BS in a chemical, biological or clinical laboratory science and 5 years of experience in clinical laboratory science education.

7. __________**Training Program Affiliates**
   - Name of laboratory
   - Address
   - Type of laboratory
   - Telephone number
   - Hospital or laboratory contact person
   - AHCA license number

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(Client 6603); (xact 1010)

Mail To: Board of Clinical Laboratory Personnel
Post Office Box 6330
Tallahassee, FL 32314-6330
http://www.floridasclinicallabs.gov/

APPLICATION CATEGORY:

(xact 1010)	Application Fee (Non-refundable)	$200.00	(xact2020) Renewal – License Fee	$300.00
	Initial License Fee	$200.00		
	TOTAL:	**$400.00**	**TOTAL:**	**$300.00**

Please review **Rule Chapter 64B3-3, F.A.C.**

PROFILE DATA: (Please print or type)

1. **PROGRAM NAME:** ____________________

MAILING ADDRESS: ____________________
(Street and Number) (Suite Number)

____
(City) (State) (Zip)

TELEPHONE: ____________________ **FAX:** ____________________

E-MAIL ADDRESS: ____________________
(**Email Notification**: If you want to be notified of the status of your application by email please check the **"YES"** box and write your email address on the line provided above. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office at info@floridasclinicallabs.gov. Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing. [ ] YES [ ] NO

ACCREDITATION PROGRAM: (Please select from one of the following categories)

- **CLP training program:**
  [ ] NAACLS [ ] CAAHEP [ ] ABHES
  or
- **Regional accrediting agency:**
  [ ] College [ ] University [ ] Vo-Tech
  or
- **Approved Laboratory - licensed under Section 483.091, F.S., or federal or out of state laboratories which have standards equivalent to those prescribed in Chapter 483, Part I, F.S., and rules:**
  [ ] Hospital/Lab

PROGRAM TYPE:

[ ] Medical Technologist (MT)
[ ] Medical Laboratory Technician – Certificate (MLT-C)
[ ] Histology
[ ] Cytology
[ ] Embryology
[ ] Molecular Pathology
[ ] Medical Laboratory Technician -MLT-AD
[ ] Immunohematology/Blood Banking
[ ] Cytogenetics
[ ] Andrology
[ ] Histocompatibility

2. EDUCATION AND TRAINING DATA:

- **Education:** (Minimum education requirements for entrance):

____
(Name of School Granting Degree) (Degree Awarded)

- **Training:** Please select the category (which includes the length of program).

SELECT ONE OPTION ONLY		CATEGORY	LENGTH of PROGRAM	COURSE TRAINING
(1)a		Clinical Chemistry, Hematology, Immunohematology, Microbiology, and Serology/Immunology – **(Combination Categories);** **and/or**	minimum (1) year; **or**	integrated instruction covering all categories
b		Indicate category (single category listed above): ____________	minimum (3) months	instruction (single category)
(2)a		Andrology; **and/or**	minimum (6) months	instruction
b		Embryology		
(3)		Histology	minimum (1) year	instruction
(4)		Cytogenetics, Radioassay, Blood Gas Analysis and Cytology – **(TECHNOLOGIST level ONLY)**	minimum (1) year	instruction
(5)		Molecular Pathology	minimum (6) months	instruction

a. Do you offer HIV/AIDS and Medical Errors education? [ ] YES [ ] NO
b. Name of Program Director (attach resume):

____
(Last) (First) (Highest Degree Held) (State License #)

c. Name of Training/Education Coordinator responsible for oversight of training program, if different than Director (attach resume):

____
(Last) (First) (Highest Degree Held) (Certification)

3. CLP TRAINING PROGRAMS – Please review **Rule Chapter 64B3-3, F.A.C.** and submit the following:

- **Personnel/Instructors Roster** (Attach personnel/faculty roster, include license number and level of licensure)
- **Student Roster** (program start and anticipated graduation date)

CLINICAL AFFILIATE LIST

AFFILIATE 1:
Name of Laboratory: ______________________ Type of Lab: ______________________

Address: ______________________ Telephone Number: ______________________
(Street and Number)

______________________ Hospital or Lab Contact: ______________________
(City) (State) (Zip)

AHCA License Number: ______________________

AFFILIATE 2:
Name of Laboratory: ______________________ Type of Lab: ______________________

Address: ______________________ Telephone Number: ______________________
(Street and Number)

______________________ Hospital or Lab Contact: ______________________
(City) (State) (Zip)

AHCA License Number: ______________________

AFFILIATE 3:
Name of Laboratory: ______________________ Type of Lab: ______________________

Address: ______________________ Telephone Number: ______________________
(Street and Number)

______________________ Hospital or Lab Contact: ______________________
(City) (State) (Zip)

AHCA License Number: ______________________

AFFILIATE 4:
Name of Laboratory: ______________________ Type of Lab: ______________________

Address: ______________________ Telephone Number: ______________________
(Street and Number)

______________________ Hospital or Lab Contact: ______________________
(City) (State) (Zip)

AHCA License Number: ______________________

AFFILIATE 5:
Name of Laboratory: ______________________ Type of Lab: ______________________

Address: ______________________ Telephone Number: ______________________
(Street and Number)

______________________ Hospital or Lab Contact: ______________________
(City) (State) (Zip)

AHCA License Number: ______________________