**American Society of Phlebotomy Technicians, Inc**.

231 Trolley Rd.

Summerville, SC 29485

843.970.8150 843.970.8152 (fax)

scoffice@asptsc.com

Please review the following information about program and instructor approval from **The American Society of Phlebotomy Technicians** Organization. We are very excited to be able to offer continuing education and training to dedicated, Healthcare Professionals across the nation. It is our mission to keep our members current in today’s healthcare world, while professionalism is one of our highest priorities at ASPT.

ASPT has so much to offer the Healthcare Professional and institutions across the nation. First, the Healthcare Professional gets more than an exam and a certificate. He or she receives a chance to participate in his or her own professional development. Consequently, the institution receives more than just a Healthcare Professional with a certificate. The institution receives a qualified Healthcare Professional with a certificate that is cost-effective for the Healthcare Professional and/or the institution to maintain. One of our primary goals is to provide reasonable low-cost continuing education programs to meet the needs of the Healthcare Professional and the institution.

Please find enclosed a program accreditation and approval packet which should provide you with some idea of what our Board of Directors has deemed to be sufficient to prepare a previously untrained person, with no medical experience, to an entry level Phlebotomist, EKG Technician, Paramedical Insurance Examiner, and Patient Care Technician/Medical Assistant. I have also enclosed some general information about ASPT. This information should give you some concept of our operating rationale and the examination procedures of ASPT.

Please note that we also have an ASPT manual along with lesson plans for each chapter. Manuals may be ordered through our Hickory office. Orders of 10 or more will receive a discount for the purchase. Please find the enclosed Chapter Lesson Plan Guide for *The Art and Science of Phlebotomy and EKG* for your preview.

We are very proud of our members and what they have helped us accomplish in the last 30 plus years. We hope that the enclosed information will help you better understand what has been accomplished with their profession and dedication to the healthcare field.

Sincerely,



 Helen Maxwell

Executive Director

Program & Instructor

Approval Packet



American Society of Phlebotomy Technicians

231 Trolley Road

Summerville, SC 29485

843-970-8150 (p)

843-970-8152 (f)

gheape@asptsc.com

 **Please mail to the above address**

American Society of Phlebotomy Technicians, Inc.

**INSTRUCTIONS FOR APPLYING FOR A.S.P.T. PROGRAM APPROVAL**

# PHLEBOTOMY TECHNICIAN

1: Carefully complete the enclosed required application.

2: **Send the application with a non-refundable application fee of $150.00 for the yearly dues to the A.S.P.T. national office. All programs expire 12-31 of each year.**

**\*\*NO REFUNDS WILL BE GIVEN.**

3: The following documents **must** be submitted with the completed application. **Only completed packages will be reviewed.** If there are missing documents, the review will not be done and there will be additional charges incurred by the facility. Use the check-off list to be sure you are submitting all necessary, required documents. Lack of these documents will result in delays in the approval process and additional expenses.

LIST OF DOCUMENTS

1. A list of instructors along with their resume, and any certificates and credentials for teaching the program. All instructors **should** be ASPT members unless waived by ASPT (ie.MT, MLT, Paramedic or RN)
2. A brochure or school catalog showing the program applying for approval.
3. A course breakdown. The number of total hours, clinical hours, didactic hours and simulated lab hours **must** be shown. It is also helpful to show how many hours are devoted to each individual subject.
4. The program outline, including the clinical portion. What exactly is being taught in each portion of the program, the objectives of the program and of the clinical portion. (Objectives are not goals.)
5. **Specific** lesson plans. These must show day-by-day, hour-by-hour what is competency and where it is covered. This requirement is most important in properly evaluating any program and without it there can be no approval.
6. A list and description of all clinical sites. What type of facility it is, how many beds/patient load, etc., **a signed contract by the facility must be submitted**, or explanation thereof.
7. Pictures of the inside and outside of the training facility must be submitted.
8. List of all equipment, especially phlebotomy and medical equipment.

PROOF OF THE FOLLOWING MUST ALSO BE SUBMITTED

1. Student malpractice insurance, if different than the school’s blanket policy.
2. A copy of how the records of grades, attendance, and tardiness are kept. There must also be a method of how the number of successful venipunctures and skin puncture are tracked. Include these forms with other documents submitted for approval.
3. A copy of the Certificate of Completion given to the student upon successful completion of the program.
4. The health form used for each student to verify they are able to participate in the training program. If there is no health requirement, a letter stating what is required to prove that the student is free from disease before admission to the program (i.e. TB Skin test, X-Ray, required vaccinations, etc.)
5. Each student must show proof of Hepatitis B vaccination or declination of such.
6. A Student Handbook given out by the facility at the beginning of the program.

This should include the following items:

* 1. Admission requirements to the program.
	2. Policy on attendance and tardiness.
	3. Grading system, and what it takes to successfully complete the program.
	4. Withdrawal and refund policy in compliance with state laws.
	5. Professional attire and appearance in the class.
	6. Program objectives.
	7. Program syllabus.

1. A Clinical Rotation and Evaluation package that goes to the clinical site. It should include:
	1. Rules and requirements of the clinical experience.
	2. Objectives of the clinical experience.
	3. Clinical evaluation sheet, signed by both the student and the trainer or supervisor. Clinical Proficiency Log to keep track of the number of venipunctures, skin punctures and procedures observed and performed.
	4. Dress code expected by the facility of the student.
	5. A statement of Waiver and Release, signed by the student, with regard to the school and clinical site for damages and training while in the program. It should also state provisions and responsibilities if the student does not complete the clinical portion of the program.
2. A written agreement between the school and the clinical site should be entered into stating specific responsibilities of the school, the clinical site, and the student.

**\*\*All programs approved by the State Department of Education, may submit to ASPT the same paperwork**

**along with the detailed lesson plans and waiver of hours,**

**ASPT will consider the approval of the program.**

SPECIFICS OF AN A.S.P.T APPROVED PHLEBOTOMY PROGRAM

1. Program length must be no less than 200 hours of combined lecture and clinical time.

1. Suggested course breakdown:

 Didactic lecture: 90 hours

 Simulated Lab: 30 hours

 Clinical Externship: 80 hours

1. A.S.P.T recommends a ratio of no more than one (1) instructor to fifteen (15) students.

## COMPETENCIES REQUIRED IN AN APPROVED PROGRAM

These competencies are **required**, but not limited to:

1. Basic laboratory terminology and abbreviations.
2. Anatomy and Physiology Suggested systems:

 Cells and Blood

 Circulation

 Heart

 Respiratory

 Lymph

 Urinary

 Muscular-skeletal

1. Blood Composition, specifics of different blood cells, function, plasma and serum.
2. Venipuncture procedures with:

Vacutainer In dwelling lines

Syringe

Butterfly

 \*\**Including specifics about the NEW Order of Draw, blood tube colors and additives*

1. Blood culture collection
2. Skin-puncture procedure including heel, finger sticks; include making blood smears
3. Responsibility and role of the phlebotomist, health care provider; where the field is headed today
4. Professionalism /HIPPA
5. Ethical and legal issues
6. Safety in the laboratory /OSHA
7. Infection and Isolation protocol /Infection Control
8. Quality control and quality assurance
9. Special and timed laboratory procedures: ABG’s, in-dwelling lines, TDM, GTT’s, etc.
10. Departments within the laboratory and the hospital
11. Processing and transporting of laboratory specimens
12. Significance of laboratory tests, as related to the body systems
13. Physical problems that can occur in the field
14. Patient types, problems and complications
15. Diseases that can affect laboratory personnel; AIDS, Hepatitis, TB
16. CPR, certificate program
17. Computer skills should be part of the program if used in the hospital and laboratory setting

Other suggestions for Phlebotomy Training Programs can include:

 Field trips to area hospitals or laboratories

 Drug Seminars

 Stress Seminars

 Cross Training in EKG and Point of Care Testing

Upon receipt of **all** documentation listed above, the review committee will review the submitted program. The decision of the review committee is final. Upon approval, an A.S.P.T Approved Program Certificate will be awarded for a period of one (1) year. The pass/fail rate for the ASPT National Phlebotomy Certification will be monitored for the first year; a 80% pass rate must be shown.

**The certificate expires on December 31st of each year.**

A.S.P.T. has the option of inspecting the training facility during the first year of approval.

**Each participant must have completed 75 successful venipunctures and 5 skin punctures, signed and dated by the instructor and is to be brought to the exam and included in the examination envelope upon completion of the test.**

 NAME OF SCHOOL/ TRAINING FACILITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PHLEBOTOMY PROGRAM APPROVAL CHECKLIST

###  List of Documents Documented No Documents

|  |  |  |
| --- | --- | --- |
| 1. Application  |   |   |
| 2. Instructor Resume Certificate * Proof ASPT Instructor, Approval
 |   |   |
| 3. Program Brochure   |   |   |
| 4. Course Breakdown  |   |   |
| 5. Program Outline * Objectives
 |   |   |
| 6. Lesson plans **by the day/week**  |   |   |
| 7. List of clinical sites  |   |   |
| 8. List of equipment  |   |   |
| 9. Entrance Exam (optional)  |   |   |
| 10. Malpractice Insurance  |   |   |
| 11. Records: * Attendance, grades
* Documented venipunctures, skin punctures.
 |   |   |
| 12. Certificate of Completion  |   |   |
| 13. Orientation Package with: * Objectives of the program Admission requirements
* Attendance requirements
* Withdrawal and refund policy
* Professional appearance
 |   |   |
| 14. Certificate of Health  Hepatitis B vaccination, or declination |   |   |
| 15. Pictures of the Training Facility  |   |   |
| 16. Clinical Rotation Package: * Objectives
* Rules and hours of work
* Documentation of procedures
* Evaluation
 |   |   |
| 17. Signed Affiliation Agreement  |   |   |

### Necessary Competencies for Phlebotomy Documented No Documents

|  |  |  |
| --- | --- | --- |
| 1. 200 hours * 1:15 ratio
 |   |   |
| 2. List of textbooks, reference books |   |   |
| 3. Terminology * Abbreviations
 |   |   |
| 4. Anatomy and Physiology: * Cells and Blood
* Heart
* Circulation
* Respiratory
* Lymph
* Urinary
* Muscular-Skeletal
 |   |   |
| 5. Blood Composition  |   |   |
| 6. Venipuncture procedures with: * Vacutainer VAD’s
* Syringe
* Winged tip device
 |   |   |
| 7. **New Order of Draw**  |   |   |
| 8. Blood Culture collection  |   |   |
|  9. Skin Punctures: * Finger
* Heel
* Making proper blood smears
 |   |   |
| 10. Role of the phlebotomist, healthcare Professional * Today’s needs
 |   |   |
| 11. Professionalism  |   |   |
| 12. Ethics * Legal Issues
 |   |   |
| 13. Safety  |   |   |
| 14. Infection control * Isolation protocol
 |   |   |
| 15. Quality Control and Quality  Assurance  |   |   |
| 16. Special and Timed lab procedures* ABG’s
* Indwelling Lines
 |   |   |
| 17. TDMs, GTTs, etc.  |   |   |

|  |  |  |
| --- | --- | --- |
| 18. Departments within the health care facility  |   |   |
| 19. Laboratory tests as related to the body’s systems  |   |   |
|  20. Processing and transporting of lab specimens  |   |   |
| 21. Physical problems that can occur  |   |   |
| 22. Patient types, problems and  complications  |   |   |
| 23. Diseases that can affect  personnel: * HBV, HIV
 |   |   |
| 24. **Certificate in CPR;** this is mandatory  |   |   |
| 25. Computer skills  |   |   |

**Each participant must have completed 75 successful venipunctures and 5 skin punctures, signed and dated by the instructor and is to be brought to the exam and included in the examination envelope upon completion of the test.**

**COMMENTS:**

Reader: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**American Society of Phlebotomy Technicians, Inc.**

### APPLICATION FOR PROGRAM APPROVAL

**(**Please print or type)

*\*\*If you are applying for MULTIPLE programs, please copy this form for EACH program approval.*

1. Name of school/training program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Address and phone of school/training program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Title of course \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Total number of students per class \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Length of course \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOURS

 Day (s) of week offered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Lecture time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOURS
2. Simulated Lab time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOURS
3. Clinical Externship time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOURS
4. Names and addresses of all participating hospitals, laboratories, or doctors in the clinical externship setting. Please submit names with an information booklet for each facility.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Use an extra page if more space is needed)

Person responsible for the trainees/program director

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of title of individual completing this application

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of school/training program applicant and title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Date of Application \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS:**

Reader: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Form A-1 (Program Approval)

**American Society of Phlebotomy Technicians, Inc.**

### APPLICATION FOR INSTRUCTOR APPROVAL

**(**Please print or type)

*\*\*If you are applying for MULTIPLE instructor, please copy this form for EACH instructor approval.*

 1. Name and title of individual applying for approval

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Address and phone of individual applying for approval \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 3. Name of school/training facility where training is held

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 4. Title of course \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Total number of students per class \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. Length of course \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOURS

 Day (s) of week offered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 7. Lecture time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOURS

 8. Simulated Lab time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOURS

 9. Clinical Externship time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOURS

 10. Names and addresses of all participating hospitals, laboratories, or doctors in the clinical externship setting.
 \**Use an extra page if more space is needed.*

* + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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 11. Person responsible for the trainees/program director

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 12. Applicant’s schedule in the school/training facility

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Applicant’s duties/ responsibilities

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of application \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following documents **must** be submitted with the completed application:

1. Must be qualified to teach. Please send a copy of your certification certificate.
2. Proof of ASPT certification at least 93%, or a waiver in with at least 90% or greater on the practical.
3. Current ASPT member.
4. Proof of current CPR certification must be submitted.
5. Must have at least 5 years’ experience in the medical environment, performing technical processes.
6. Must submit 3 letters of reference attesting to experience in the healthcare environment and teaching and training.
7. Current resume.
8. Proof of **at least** six (6) hours of continuing medical education during the previous year.
9. Must submit a **detailed** course outline of how you teach the program. This **MUST** include lesson plans.
10. The enclosed application properly filled out.

NAME OF INSTUCTOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF SCHOOL/ FACILITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECKLIST FOR INSTRUCTOR APPROVAL

 List of Documents Documented No Documents

|  |  |  |
| --- | --- | --- |
| 1. Application  |   |   |
| 2. Qualification for Instructor  |   |   |
| 3. ASPT Certification with 93% or better  Waiver with 90% or better  |   |   |
| 4. **Current** ASPT membership  |   |   |
| 5. **Current** CPR certified  |   |   |
| 6. 5 years’ laboratory experience  |   |   |
| 7. 3 Letters of Recommendation  |   |   |
| 8. Current Resume  |   |   |
| 9. Proof of 6 hours of continuing education within the last year  |   |   |
| 10. Current lesson plans and course outline  |   |   |
| 11. $100.00 Application Fee  |   |   |

**COMMENTS:**

Reader: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Form A-2 (Instructor Approval)

**American Society of Phlebotomy Technicians, Inc.**

**INSTRUCTIONS FOR APPLYING FOR ASPT ELECTROCARDIOGRAPHY PROGRAM APPROVAL**

* 1. Carefully complete the enclosed application.
	2. **Send the completed application with the non-refundable application fee of $150.00 to the A.S.P.T’s National Office. NO REFUNDS WILL BE GIVEN.**
	3. Submit those with the following documents. **ONLY COMPLETE PACKAGES** **WILL BE REVIEWED.** If an incomplete package is submitted, no review will be done, and there may be additional charges incurred by the facility. Use the enclosed Check-off list to be sure you are enclosing the required materials. Lack of these documents will result in approval delays and additional charges.

### LIST OF DOCUMENTS

* A list of instructors, along with their resume, a copy of any of their licensure and credentials for teaching this program. The instructor must be a Health Care Professional already in the field.
* A brochure or school catalog showing the Electrocardiography Program
* A course breakdown. This must show **total** hours of the program, and a breakdown of the hours spent on each part of the program. Example: Heart – 6hours, Circulatory System – 6 hours, etc.
* The Program Outline. Each part **must** include **exactly** what is taught in each portion of the program.
* Please include the objectives of each part of the program, and objectives of the whole program.
* Objectives are not goals.
* **SPECIFIC lesson plans.** These must show day-by-day, hour-by-hour what is being covered in each session. A cross-reference is handy to show each competency and where it is covered.

**THIS REQUIREMENT IS MOST IMPORTANT TO PROPERLY EVALUATE THE PROGRAM. THERE WILL BE NO PROGRAM APPROVED WITHOUT IT.**

* Pictures of the training facility.
* A list of equipment, especially the type (s) of electrocardiogram the students are using. There should also be some type of screen, or privacy curtain or privacy capes available.
* All programs approved by the State Department of Education, may be submitted to ASPT. This same paperwork, along with **detailed lesson plans** and number of hours will be considered for the approval.

PROOF OF THE FOLLOWING **MUST** ALSO BE SUBMITTED

1. Student malpractice insurance if different than the school’s blanket policy.
2. A copy of grade, attendance and tardiness records. This can be the generic form, not the one with names, etc. on it.
3. A copy of the Certificate of Completion given to the student after completing the program.
4. Any documentation health form used to assure that the student can participate in the program.
5. Proof of the HBV immunization, or the declination thereof.
6. A Student Handbook given to each participant, covering the following:

 A. Guidelines for admission to the program.

* 1. Rules regarding attendance and tardiness.
	2. Dress code for the program.
	3. Program objectives.
	4. A class syllabus.
	5. Grading policy, including what is required to successfully complete the program
	6. Withdrawal and refund policy in compliance with state laws.

**SPECIFICS OF AN A.S.P.T. APPROVED ELECTROCARDIOGRAPHY PROGRAM**

1. A program of no less than **40 hours.**
2. **A minimum** of five (5) electrocardiographs done in class. An additional mounted **EKG,** properly labeled, signed and dated by the instructor is to be brought to the exam by the student and placed in the examination envelope upon completion of the test.
3. A list of all reference and textbooks used in the program.
4. The following competencies are to be included in an approved Electrocardiography Program:

 A. Anatomy of the:

* + 1. Heart, in depth
		2. Circulatory System, in depth
		3. Conduction System
	1. Electrocardiography, heart and circulatory system terminology and abbreviations
	2. Electrocardiography:

 1. Parts of an EKG instrument

* + - * 1. EKG paper calculations
				2. Standardization
				3. Marking codes
				4. Patient preparation; patient dignity
				5. Leads
				6. EKG waves and their relation to heart action
				7. Common artifacts seen in an EKG
				8. Cardiac arrhythmias and blocs
				9. Proper electrode placement

 5. Lab practice:

A. Time allowed for the student to practice doing EKG’s, cut and mount them, with basic interpretation.

 6. **CPR Certification mandatory**

Upon receipt of ***all*** documentation listed above, the review committee will review the submitted program. The decision of the committee is final. Upon approval, an A.S.P.T. a Certificate of Program Approval will be awarded for a period of one (1) year. The pass/fail rate for the National Electrocardiography Certification Examination will be monitored for the first year; a 80% rate must be shown.

**The Certificate of Approval expires December 31st of each year.**

A.S.P.T. has the option of inspecting the training facility during *the first year of approval*.

NAME OF SCHOOL/TRAINING FACILITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### ELECTROCARDIOGRAPHY PROGRAM APPROVAL CHECK LIST

|  |  |  |
| --- | --- | --- |
|   | DOCUMENTS  | NO DOCUMENTS  |
| 1. Properly completed application  |   |   |
| 2. Application and yearly fees  |   |   |
| 3. Instructors: * Resume
* Copy of licensure
* Health care professional
 |   |   |
| 4. School/training facility brochure  |   |   |
| 5. Course breakdown  |   |   |
| 6. Program outline  |   |   |
| 7. Specific lesson plans  |   |   |
| 8. Pictures of school/training facility  |   |   |
| 9. List of equipment  |   |   |
| 10. Entrance exam (optional)  |   |   |
| 11. Student Malpractice Insurance  |   |   |
| 12. Grading, attendance and tardiness form (s)  |   |   |
| 13. Certificate of Completion  |   |   |
| 14. a. Letter about health requirements, or for  b. HBV immunization form and declination form  |   |   |
| 15. Student Handbook: 1. Guidelines for program admission
2. Rules on absences and tardiness
3. Dress code
4. Program objectives
5. Class syllabus
6. Grading policy; minimum passing grade
7. Withdrawal and refund policy
 |   |   |

|  |  |  |
| --- | --- | --- |
| **NECESSARY COMPETENCIES FOR ELECTROCARDIOGRAPHY APPROVAL**  | DOCUMENTS  | NO DOCUMENTS  |
| 1. Program is at least **40 hours**  |   |   |
| 2. The student does at **least 5** EKG’s **and 1** additional **EKG to be mounted and labeled properly; signed and dated** by the instructor To be submitted with examination.  |   |   |
| 3. A list of reference and textbooks used  |   |   |
| 4. Anatomy and Physiology: 1. The heart, in detail
2. The Circulatory System, in detail
3. The Conduction System, in depth
 |   |   |
| 5. EKG, heart, circulation and conduction  systems Terminology and abbreviations  |   |   |
| 6. Electrocardiography: 1. Parts of the EKG instrument
2. EKG paper calculations
3. Standardization
4. Marking codes
5. Patient preparation; dignity, proper lead placement
6. Leads
7. EKG waves; relation to heart action
8. Common artifacts
9. Cardiac arrhythmias and blocks
 |   |   |
| 7. Lab practice: what is covered in each lab practice, and number of hours spent in each lab session.  |   |   |
| 8. CPR Certification (There must be a CPR Certificate awarded)  |   |   |

**COMMENTS:**

Reader: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**American Society of Phlebotomy Technicians, Inc.**

### INSTRUCTIONS FOR APPLYING FOR ASPT PATIENT CARE TECHNICIAN PROGRAM/

### MEDICAL ASSISTING PROGRAM APPROVAL

1. Carefully complete the enclosed application.
2. **Send the completed application with the non-refundable application fee of $150.00 to the A.S.P.T’s National Office. NO REFUNDS WILL BE GIVEN.**
3. Submit those with the following documents.

**ONLY COMPLETE PACKAGES WILL BE REVIEWED.**

If an incomplete package is submitted, no review will be done, and there may be additional charges incurred by the facility. Use the enclosed Check-off list to be sure you are enclosing the required materials. Lack of these documents will result in approval delays and additional charges.

### LIST OF DOCUMENTS

* A list of instructors, along with their resume, a copy of any of their licensure and credentials for teaching this program. The instructor must be a Health Care Professional already in the field.

\*\***All Program Directors and the instructors MUST be ASPT Approved Instructors.**

* A brochure or school catalog showing the Patient Care Technician Program/ Medical Assisting Program
* A course breakdown. This must show **total** hours of the program, and a breakdown of the hours spent on each part of the program. Example: Heart – 6 hours, Circulatory System – 6 hours, etc.
* The Program Outline. Each part **must** include **exactly** what is taught in each portion of the program. \*\*Please include the objectives of each part of the program and objectives of the whole program. Objectives are not goals.
* **SPECIFIC lesson plans.** These must show day-by-day, hour-by-hour what is being covered in each session. A cross-reference is handy to show each competency and where it is covered. **THIS**

**REQUIREMENT IS MOST IMPORTANT TO PROPERLY EVALUATE THE PROGRAM. THERE WILL BE NO PROGRAM APPROVED WITHOUT IT.**

* Pictures of the training facility.
* A list of equipment, especially the type (s) of equipment the students are using. There should also be some type of screen, or privacy curtain available when EKG’s are taught..
* All programs approved by the State Department of Education, may be submitted to ASPT the same paperwork, along with **detailed lesson plans.**

PROOF OF THE FOLLOWING **MUST** ALSO BE SUBMITTED

1. Student malpractice insurance if different than the school’s blanket policy.
2. A copy of grade, attendance and tardiness records. This could be the generic form, not the one with names, etc. on it.
3. A copy of the Certificate of Completion given to the student after completing the program.
4. Any documentation health form used to assure that the student is able to participate in the program.
5. Proof of the HBV immunization, or the declination thereof.
6. A Student Handbook given to each participant, covering the following:
	1. Guidelines for admission to the program.
	2. Rules regarding attendance and tardiness.
	3. Dress code for the program.
	4. Program objectives.
	5. A class syllabus.
	6. Grading policy, including what is required to successfully complete the program
	7. Withdrawal and refund policy in compliance with state laws.

**SPECIFICS OF AN A.S.P.T APPROVED**

**PATIENT CARE TECHNICIAN/ MEDICAL ASSISTING PROGRAMS**

A PCT program of no less than **300 hours.** An MA program of no less than **450 hours.**A list of all reference and text books used in the program.
The following competencies are to be included in an approved Program:

1. Introduction to Patient Care Technician/ Medical Assistant

Job responsibilities

Professionalism

Communication skills

QC/QA

1. OSHA and Safety

General safety

Emergency response protocol

Safe disposal

Fall prevention

Body mechanics

Incident reports

Patient restraints (PCT)

Ergonomics (MA)

1. Medical terminology

Common terms

Accepted medical abbreviations

Prefix, Suffix, Root word, Combining forms

1. Law and Ethics

Making Ethical Decisions

Preventing Medical Malpractice

Informed Consent

HIPAA

Drug Regulations

1. Infection Control

Hand washing

Universal precautions

Sterilization

Blood borne pathogens

Preparing a sterile field

Assisting with sterile/ surgical procedures

1. Anatomy and Physiology

Cardiovascular system

Respiratory system

Gastrointestinal system

Genitourinary system

Musculoskeletal system

Nervous system

Integumentary system

1. Patient Care

In-patient duties

Out-patient duties

Nutrition

Vital signs and Measurements

Patient history

Special collections

Special patient treatment care

Pre and Postoperative care

1. Departments within the laboratory

Hematology

Chemistry

Blood bank

Microbiology

Serology

Special departments

1. Phlebotomy supplies
2. Phlebotomy technique using all types of collection equipment (75 venipunctures ,5 skin punctures)
3. Blood tests and their relation and significance to the body
4. The proper order of draw
5. Factors to consider before doing a blood collection
6. Complications associated with blood collection
7. Finger and heel collection; the equipment needed
8. Special laboratory blood tests
9. Point of Care Testing (FOUR (4) hours of training for each POCT test is required)
10. D.O.T. collection
11. Electrocardiography
12. QA/QC
13. EKG terminology
14. EKG supplies listed; type of instruments, etc.
15. Understanding of a cardiac cycle, and how it related to the EKG
16. Know the purpose of an EKG
17. Know why and how an EKG is standardized
18. Explain the components of an EKG
19. List the 12 leads on an EKG
20. Know the placement of the 6 chest leads
21. Know common artifacts in an EKG
22. Patient prep for an EKG
23. Run 5 EKG’s and mount 1 EKG ‘s for exam

**Each participant must have completed at least five (5) electrocardiograms. An additional mounted EKG, properly labeled, signed and dated by the instructor is to be brought to the exam and included in the examination envelope upon completion of the test.**

**Medical Assisting Programs will need to add the following competencies:**

1. Office Management

 Medical Records/ Documentation

 EHR

 Scheduling

1. Insurance and Coding

 Insurance Types- Medicaid and Medicare

 Diagnostic Coding

 Procedural Coding

 ICD-10-CM

1. Pharmacology

 Math for Medical Professionals

 Calculating Dosage

 Drug Classifications

 Medication Order

 “Seven” Rights of drug administration

 Parenteral Medicine/ Equipment and Administration

 Non-parenteral Medicine/ Equipment and Administration

 Medication and the Uses

Upon receipt of ***all*** documentation listed above, the review committee will review the submitted program.

The decision of the committee is final. Upon approval, an A.S.P.T. Certificate of Program Approval will be awarded for a period on one (1) year. The pass/fail rate for the ASPT National Patient Care Technician Certification Examination will be monitored for the first year; a 80% rate must be shown.

**The Certificate of Approval expires December 31 of each year.**

A.S.P.T. has the option of inspecting the training facility during the first year of approval.

\*Enough time must be given for the participant to practice each skill they learn, through a simulated clinic or hospital setting.

**Each participant must have completed 75 successful venipunctures and 5 skin punctures, signed and dated by the instructor and is to be brought to the exam and included in the examination envelope upon completion of the test.**

 NAME OF SCHOOL/TRAINING FACILITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CARE/ MEDICAL ASSISTING PROGRAM APPROVAL CHECK LIST**

|  |  |  |
| --- | --- | --- |
|   | DOCUMENTS  | NO DOCUMENTS  |
| 1. Properly completed application  |   |   |
| 2. Application and yearly fees  |   |   |
| 3. Instructors: * Resume
* Copy of licensure
* Health care professional
 |   |   |
| 4. School/training facility brochure  |   |   |
| 5. Course breakdown  |   |   |
| 6. Program outline  |   |   |
| 7. Specific lesson plans  |   |   |
| 8. Pictures of school/training facility  |   |   |
| 9. List of equipment  |   |   |
| 10. Entrance exam (optional)  |   |   |
| 11. Student Malpractice Insurance  |   |   |
| 12. Grading, attendance and tardiness form (s)  |   |   |
| 13. Certificate of Completion  |   |   |
| 14. a .Letter about health requirements, or for  b. HBV immunization form and declination  form |   |   |
| 15. Student Handbook: 1. Guidelines for program admission
2. Rules on absences and tardiness
3. Dress code
4. Program objectives
5. Class syllabus
6. Grading policy; minimum passing grade
7. Withdrawal and refund policy
 |   |   |

|  |  |  |
| --- | --- | --- |
| **NECESSARY COMPETENCIES FOR APPROVAL**  | DOCUMENTS  | NO DOCUMENTS  |
| 1. **5** documented EKG’s **and I** additional **EKG to be mounted and labeled; 75 successful venipunctures and 5 skin punctures properly signed and dated** by the instructor to be submitted with examination.  |   |   |
| 2. A list of reference and textbooks used  |   |   |
| 3. Introduction to PCT/ MA 1. Job responsibilities
2. Communication skills
3. Professionalism
4. QA/QC
 |   |   |
| 4. Safety/OSHA  |   |   |
| 5. Medical Terminology  |   |   |
| 6. Law and Ethics |   |   |
| 7. Infection Control |  |  |
| 8. Anatomy and Physiology 1. Cardiovascular
2. Respiratory
3. Gastrointestinal
4. Genitourinary
5. Musculoskeletal
6. Nervous
7. Integumentary
 |   |   |
| 8. Patient Care 1. In-patient duties
2. Out-patient duties
3. Nutrition
4. Vital signs and Measurements
5. Patient History
6. Special collections

 1. Urine  2. Stool  3. Sputum 1. Special treatment care

 1. IV sites  2. Pulse ox 1. Pre- and post op

1. Consent 2. Check lists 3. Pre op meds 4. NPO 5. Surgical preps 6. Post op breathing, coughing, position, etc. 7. Monitoring vital signs  |   |   |

|  |  |  |
| --- | --- | --- |
| 9. Number of hours in the simulated lab/clinic setting  (Be Specific)  |   |   |
| 10. Departments within the lab  a. What tests are drawn for each section  |   |   |
| 11. Phlebotomy supplies  |   |   |
| 12. Techniques using all types of equipment 1. Vacutainer VAD’s
2. Syringe
3. Winged tip device
 |   |   |
| 12. Blood test and their relation to body systems  |   |   |
| 13. **Proper Order of Draw** What order of draw the program teaches  |   |   |
| 14. Factors affecting blood test results  |   |   |
| 15. Complications associated with blood collection  |   |   |
| 16. Skin punctures 1. Finger
2. Heel
3. Equipment
 |   |   |
| 17. Special laboratory blood tests 1. GTT
2. TDM
3. Fasting
4. Blood cultures
5. Chloride Sweat Test
6. PKU
7. Bleeding times, etc.

**\*\*\*\*\* Please be specific on which tests are taught in the curriculum.**  |   |   |
| 18. Point of Care Testing  **A minimum of 4 hours is required for each test being taught.****\*\*\*Be specific which POCT tests are covered.**  |   |   |
| 19. D.O.T. Drug collection  |   |   |
| 20. Number of hours allotted for practice time so each participant can become proficient before being allowed to draw “real” patients.  |   |   |
| 21. QA/QC  |   |   |
| 22. EKG Terminology  |   |   |
| 23. Supplies. Please list the type(s) of EKG instrument(s) being used.  |   |   |
| 24. Explanation of: 1. Cardiac Cycle; its relationship to the EKG
2. Purpose of an EKG
3. How and why and EKG is standardized
4. Components of an EKG
5. 12 leads
6. Placement of leads, and 6 chest leads
7. Common artifacts
8. Patient preparation
 |   |   |
| 25. Running and mounting of an EKG  |   |   |
| 26. At least 5 complete EKG’s during the course  |   |   |
| 27. Practice time (be specific in number of hours)  |   |   |
| **Medical Assisting Program only:** |  |  |
| 28. Office Management |  |  |
| 29. Insurance and coding and pharmacology1. Math for Medical Professionals
2. Calculating Dosage
3. Drug Classifications
4. Medication Orders
5. “Seven” Rights of Drug administration
6. Parenteral Medicine
7. Non-parenteral Medicine
8. Medication and their uses
 |  |  |

 **COMMENTS:**

Reader: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**American Society of Phlebotomy Technicians, Inc.**

### INSTRUCTIONS FOR APPLYING FOR ASPT PARAMEDICAL INSURANCE EXAMINER PROGRAM APPROVAL

**(**Please print or type)

1. Carefully complete the enclosed application.
2. **Send the completed application with the non-refundable application fee of $150.00 to the A.S.P.T’s National Office. NO REFUNDS WILL BE GIVEN.**
3. Submit those with the following documents, with the application and appropriate fees. **ONLY COMPLETE PACKAGES WILL BE REVIEWED.**

If an incomplete package is submitted, no review will be done, and there may be additional charges incurred by the facility. Use the enclosed Checkoff list to be sure you are enclosing the required materials. Lack of these documents will result in approval delays and additional charges.

### LIST OF DOCUMENTS

* A list of instructors, along with their resume, a copy of any licensure and credentials that verifies their ability to teach the program. The instructor must be a health care professional already in the field. **All Instructors MUST be ASPT Approved by ASPT.**
* A brochure or school catalog showing the Paramedical Program Insurance.
* A course breakdown. This must show **total** hours of the program, and a breakdown of the hours spent on each part of the program. Example: Heart – 6 hours, Circulatory System – 6 hours, etc.
* The Program Outline. Each part **must** show **exactly** what is taught in each portion of the program. Please include the objectives of each part of the program and objectives of the whole program. Objectives are not goals.
* **Specific lesson plans.** These must show day-by-day, hour-by-hour what is being covered in each session. A cross-reference is handy to show each competency and where it is covered. **THIS REQUIREMENT IS THE MOST IMPORTANT TO PROPERLY EVALUATE THE PROGRAM. THERE WILL BE NO PROGRAM APPROVED WITHOUT THESE LESSON PLANS AS DESCRIBED ABOVE.**
* Pictures of the training facility.
* A list of equipment, especially the type (s) of electrocardiograph machines the students are using. There should also be some type of screen, or privacy curtain available.
* All programs approved by the State Board of Education, may be submitted the same paperwork to A.S.P.T.with **Detailed lesson plans.**

**PROOF OF THE FOLLOWING MUST ALSO BE SUBMITTED**

* Student malpractice insurance if different than the school’s blanket policy, the student is the actual policyholder and is covered until graduation.
* A copy of grade, attendance and tardiness records. This could be the generic form, not the one with names on it.
* A copy of the Certificate of Completion given to the student after completing the program.
* Any documentation health form used to assure that the student can participate in the program.
* Proof of the HBV immunization, or the declination thereof.
* A Student Handbook given to each student, covering the following:

 **\*\*Applicant must already be a Certified Phlebotomy Technician.**

* Guidelines for admission to the program.
* Rules regarding attendance and tardiness
* Dress code for the program
* Program objectives
* A class syllabus
* Grading policy, and information on requirements necessary for successfully completing the program
* Withdrawal and refund policy in compliance with state laws

### SPECIFICS OF AN APPROVED PARAMEDICAL INSURANCE EXAMINER PROGRAM

1. A program of no less than **40 hours.**
2. **A minimum** of two (2) electrocardiograms, and a minimum of 5 completed medical history and insurance forms. At the time of the certification examination, the participant must submit 2 completed medical history and insurance forms and 1 additional EKG properly labeled, signed and dated by the instructor and put in the test envelope along with the completed answer sheet and test booklet.
3. A list of all reference and textbooks used in the program.
4. The following competencies are to be included in an Approved Paramedical Insurance Examiner Program:
* Guidelines for a Paramedical Insurance Examiner:
1. Responsibilities
2. Limitations ii.
* Health history; process of interviewing
	+ 1. Physician’s office
		2. Life Insurance Company
		3. Error handling iii.
* Vital Signs (measuring and understanding factors affecting the vital signs)
* Blood pressure
* Temperature
* Pulse
* Respirations
1. Anthropometric Measurements
2. Urinalysis
	1. Types
	2. Control Strips
	3. Reagent Strips
3. Performing a proper venipuncture
4. Performing a proper skin puncture
5. Electrocardiography
	1. Parts of an EKG instrument
	2. EKG paper
	3. Standardization
	4. Marking codes
	5. Patient preparation
	6. Leads
	7. Common artifacts seen in an EKG
6. Anatomy and Physiology review of the following body systems:
	1. blood, blood cells, and its/their function
	2. Heart and the conduction system
	3. Circulatory system
7. Lab Practice
	1. Time allowed for the student to practice doing EKG’s, cut and mount them
	2. To complete 5 health histories and insurance forms
	3. Complete 5 successful sets of vital signs
	4. Completion of at least 5 Quality Control Check-Stix and urine dipstick procedures.
	5. Completion of at least 10 venipunctures and 5 skin punctures
8. Practice at least 2 DBS
9. HIPPA/OSHA/Infection Control
10. CPR certification is mandatory

Upon receipt of ***all*** documentation listed above, the review committee will review the submitted program. The decision of the committee is final. Upon approval, an A.S.P.T. a Certificate of Program Approval will be awarded for a period of one (1) year. The pass/fail rate for the ASPT National Electrocardiography Certification Examination will be monitored for the first year. A pass rate of 80% must be shown.

**The Certificate of Approval expires December 31st of each year.**

A.S.P.T. has the option of inspecting the training facility during the first year of approval.

**Only approved programs may test their students directly upon graduation. For all other programs, the students must have a minimum of six (6) months experience doing paramedical examinations**.

NAME OF SCHOOL/TRAINING FACILITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARAMEDICAL INSURANCE EXAMINER PROGRAM APPROVAL CHECK LIST**

|  |  |  |
| --- | --- | --- |
|   | DOCUMENTS  | NO DOCUMENTS  |
| 1. Properly completed application  |   |   |
| 2. Application and yearly fees  |   |   |
| 3. Instructors: * Resume
* Copy of licensure
* Health care professional
 |   |   |
| 4. School/training facility brochure  |   |   |
| 5. Course breakdown  |   |   |
| 6. Program outline  |   |   |
| 7. Specific lesson plans  |   |   |
| 8. Pictures of school/training facility  |   |   |
| 9. List of equipment  |   |   |
| 10. Entrance exam (optional)  |   |   |
| 11. Student Malpractice Insurance  |   |   |
| 12. Grading, attendance and tardiness form(s)  |   |   |
| 13. Certificate of Completion  |   |   |
| 14. a. Health requirement form  b. HBV immunization, declination   |   |   |
| 15. Student Handbook: 1. Admission requirements
2. Attendance, tardiness rules
3. Dress code
4. Program objectives
5. Class syllabus
6. Grading policy; minimum passing grade
7. Withdrawal and refund policy
 |   |   |

#### NECESSARY COMPETENCIES FOR PARAMEDICAL INSURANCE EXAMINER PROGRAM APPROVAL

|  |  |  |
| --- | --- | --- |
| A minimum of 40 hours  | DOCUMENTS  | NO DOCUMENTS  |
| 1. Minimum: * EKG’s
* 5 Medical History Insurance Forms
 |   |   |
| 2. Guidelines for PMIE* Responsibilities
* Limitations
 |   |   |
| 3. Health History: * Interviewing
* Physician’s office
* Life Insurance Company
* Error handling
 |   |   |
| 4. Vital signs (measuring, understanding) * Blood pressure
* Temperature
* Pulse
* Respirations
 |   |   |
| 5. Anthropometric Measurements  HIPPA/OSHA |   |   |
| 6. Urinalysis * Types
* Control strips
* Reagent strips
 |   |   |
| 7. Performing venipunctures  |   |   |
| 8. Performing skin punctures  |   |   |
| 9. Electrocardiography: * Parts of an EKG machine
* EKG paper
* Standardization
* Marking codes
* Patient preparation
* Leads
* Common artifacts

  |   |   |
| 10. Anatomy and Physiology Review: * Blood, blood cells, and function of each heart and conduction system
* Circulatory system
 |   |   |

American Society of Phlebotomy Technicians, Inc.

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828.327.2969 (fax) office@aspt.org

[www.aspt.org](http://www.aspt.org/)



Please review the following information about setting up an ASPT exam. Attached you will find a set-up sheet. Please fill this form out completely and fax /scan and email back to the office. We will make a flyer for you unless you request an in-house exam. When we make the flyer for your exam we will fax it back to you for your approval. When you receive the flyer, please check carefully for any typographical errors. Once you have checked the flyer and approved it, fax us your approval and/or corrections. When the flyer has been approved by you, you may make copies and distribute. Remember all fees must be in our office **thirty days prior to the event**. **PLEASE** read the flyer very carefully.

Your exams will be mailed by UPS two weeks prior to the exam date. If your package has not arrived three days before the exam, notify us immediately so we can track the package. **SEE EXAM FEES BELOW:**

**Phlebotomy $90 <30 days in advance $115 EKG $90 <30 days $115**

**PCT $165 <30 days in advance $190 MA $165 <30 days $190**

Thank you again for your participation in helping others to be successful in their profession. We look forward to working with you.

Sincerely,



Helen Maxwell

ASPT Director

 **American Society of Phlebotomy Technicians, Inc.**

PO Box 1831

Hickory, NC 28603 828.327.3000

828.327.2969 (fax) office@aspt.org

[www.aspt.org](http://www.aspt.org/)

Examination Set-Up Sheet

Print and fill out complete form for **EACH** exam.

Must be completed **60 days prior** to the exam.

**Today’s Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

Name of person setting up exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of exam\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Time of exam\_\_\_\_\_\_\_/AM/PM (circle one)

Location of exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bldg\_\_\_\_\_Room\_\_\_\_\_Floor\_\_\_\_\_\_\_

 City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_ Fax ( )\_\_\_\_\_\_\_\_\_\_\_\_

##### Tests are to be sent to the following person and location: Tests should arrive one week prior to the exam. Must be a physical address (NO PO Box) TESTS CAN NOT BE SENT TO A HOME ADDRESS

Send tests to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Room/Bldg\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\*\*Day phone # ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax # ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Please provide us with your email address:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check One:** Does the monitor need any equipment to administer the practical portion of the test?

Y\_\_\_\_N\_\_\_\_ If so, list supplies needed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need a monitor to come in and administer the national exam? (Certain number of participants needed)

Can this exam be opened to Health Care Professionals outside of your faculty Y\_\_\_\_\_ N \_\_\_\_?