

TRAINING PROGRAM INSTRUCTIONS

Department of Health
Board of Clinical Laboratory Personnel
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257
(850) 245-4355

www.doh.state.fl.us/mqa/ClinLab/index.html

Please read the following instructions before completing the application:

1. All information must be printed in black ink or be typewritten.
2. Attach a certified check or money order to the application payable to the Department of Health. **Do not send cash.**
3. All training programs (universities, community colleges, vocational technical schools, hospitals or laboratory based) for laboratory personnel should complete this application.
4. All programs must complete all portions of this application except where stated for nationally accredited programs.
5. All programs shall attach a list of trainees at the time of initial and renewal application.
6. If a trainee needs to extend his/her registration, the program director will submit the appropriate form requesting to extend trainee license.

COMPLETING THE APPLICATION:

EDUCATION AND TRAINING DATA

Please list the minimum education requirements and degree granted from this program if applicable. State the estimated number of trainees and length of training including the starting and ending dates. List where in the curriculum the HIV/AIDS training is taught. State the names of the coordinator and director of the program, highest degree attained, and licensure status. If the director is a physician, enter the medical license number (ME); or if the director is licensed under Chapter 483, Part III. F. S., indicate their license number. Attach a resume if this is an initial application or if the information has changed.

INITIAL AND RENEWAL FEES

Initial Application Fee - \$200.00 (non-refundable)

Initial Licensure Fee - \$200.00

Unlicensed Activity Fee - \$5.00

Total: \$405.00

Renewal Fee - \$300.00

Unlicensed Activity Fee - \$5.00

Total: \$305.00

Late filed renewal fee of \$50 if you are renewing after the expiration date.

PERSONNEL ROSTER

Attach a personnel roster. Be sure to list all laboratory personnel including the level of licensure and license number.

TEACHING STAFF

Attach a list of the faculty including the degree and licensure status.

TRAINING SCHEDULE

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.

***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.**

DH-MQA 3007 Revised 11/08

Rule 64B3-3.001, F.A.C.

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PROGRAM NAME: _____

- a. Where in your curriculum is HIV/AIDS education taught? _____
- b. Name of training coordinator/person responsible for oversight of training _____
(Attach Resume) Highest Degree Held: _____ Certification: _____
- c. Name of Medical Director _____
(Attach Resume) Highest Degree Held: _____ State License #: _____

3. PERSONNEL ROSTER (Attach a personnel roster) Include level of licensure and license number.

4. TEACHING STAFF (Attach a list of teaching staff, including the degree and licensure status)

5. TRAINING SCHEDULE – List the amount of time the trainee will spend in each of the areas.

Subject	Hours of Practical Lab Work	Hours Spent in Lecture
Clinical Chemistry	_____	_____
Urinalysis	_____	_____
Serology/Immunology	_____	_____
Hematology	_____	_____
Bacteriology	_____	_____
Parasitology	_____	_____
Immunochemistry	_____	_____
Blood Gas	_____	_____
Radioassay	_____	_____
Histology	_____	_____
Cytology	_____	_____
Other (Specify)	_____	_____

6. TRAINING PROGRAM CHECKLIST:

- a. Do you keep a file on each student? Yes No
- b. Programs that are not nationally accredited must submit a self-study document initially and within 6 months of major changes.
 Attached Submitted 20_____
- c. Attach the most current laboratory inspection survey if the program is laboratory based.
- d. The following material, other than the routine laboratory specimen, is available for the trainee: Film Slide projector
 Biological material Film strips Microscopic slides of prepared specimens
 Other (Specify) _____
- e. Is a lecture room available? Yes No
- f. Are major technical journals and reference books available to trainees? Yes No
- g. Do you have the students evaluate your program? Yes No
- h. Do you have the graduates evaluate your program? Yes No
- i. Trainees:
 - Does the program ensure that students are not substituted for regular staff in the laboratory? Yes No
 - Are all of your trainees registered when enrolled in the practicum portion of the Training Program? Yes No
 - Do your trainees work under direct supervision? Yes No
 - Do your trainees report results? Yes No
 - Do your trainees receive current copies of the laws and rules governing clinical laboratories? Yes No
- j. Does the program's curriculum comply with the Board Rule 64B3-3.003, F.A.C.? Yes No
- k. Does your program meet the health science framework standards set forth by the Florida Department of Education at http://www.fldoe.org/workforce/dwdframe/he_cluster_frame08.asp ? Yes No
- l. Does the program provide instruction in venous and capillary blood specimens and didactic training in arterial blood collection? Yes No
- m. Does the program have a didactic element and a practicum? Yes No
- n. Does the program have a 1:1 ratio of technologist/supervisor per trainee or 1:3 ratio of training program instructor per trainee? Yes No
- o. Do you employ systematic procedures for assessing learning outcomes, and the affective, cognitive and psychomotor domains? Yes No
- p. Do you employ state-of-the-art instructional aides and methodologies for teaching the affective, cognitive and psychomotor domains? (e.g., practice specimens, student slides, special kits, etc.) Yes No

PROGRAM NAME: _____

7. APPLICANT STATEMENT:

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

I state that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.082, 775.083, and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions, organizations, my references, personal physicians, employers (past and present), and all government agencies and instruments (local, state, federal, or foreign) to release to the Department of Health any information, files and/or records requested by the Department of Health in connection with the processing of this application. I further authorize the Department of Health to release to the organization, individuals, and groups listed above any information which is material to my application.

I understand that Florida law requires me, as an applicant for licensure, to supplement my application after it has been submitted with any material change in circumstances or conditions which might affect the Board of Clinical Laboratory's decision concerning my eligibility for licensure (Section 456.013, Florida Statutes). Failure to do so may result in denial of licensure and/or other action by the Board of Clinical Laboratory Personnel.

I further state that I have carefully read the questions in the foregoing application and have answered them completely without reservation of any kind and I declare that the answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension, or revocation of the license for which I am applying.

I also state that I will comply with all requirements for licensure renewal in effect at the time of licensure renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

I understand that an incomplete application shall expire one year after initial filing with the Department of Health as stated in Section 456.013(1)(a), Florida Statutes.

(Signature of Applicant)

(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)

AFFILIATE 2:

Name of Laboratory: _____ Type of Lab: _____

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

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

AFFILIATE 3:

Name of Laboratory: _____ Type of Lab: _____

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

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

AFFILIATE 4:

Name of Laboratory: _____ Type of Lab: _____

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

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

AFFILIATE 5:

Name of Laboratory: _____ Type of Lab: _____

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

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

AFFILIATE 6:

Name of Laboratory: _____ Type of Lab: _____

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

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

AFFILIATE 7:

Name of Laboratory: _____ Type of Lab: _____

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

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