Phlebotomy Technician Certification Critical Skill Competency/Qualification by Experience Documentation

2025 - Louisiana

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

Name of Applicant _____

Today's Date (mm/dd/yyyy) _____ NCCT User ID # _____

The remainder of this form is to be completed by the applicant's school official or direct patient care supervisor which may include, but not limited to, a licensed physician or primary care provider.

The person named above is applying for certification in the field of Phlebotomy Technician. For those applying via the experience pathway, the documentation must reflect a minimum of one (1) year full-time work experience, within the past five (5) years as a Phlebotomy Technician. In order to determine the eligibility of the applicant, we require verifiable documentation of knowledge, education, training, and proficiency in the critical skill areas as identified below. Please complete the documentation below. Only one (1) school official or direct patient care supervisor per page.

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.

Critical Skill Performance Competency	***Supervisor's Initials***
Venipuncture *(performance of a minimum of 100 venipuncture procedures)*	
Capillary puncture *(performance of a minimum of 25 capillary puncture procedures)*	
Additional comments *(optional):*	

If this applicant was employed by your organization in a full-time capacity in the last five (5) years and that employment includes successful performance in the critical skills, please provide the dates of full-time employment (defined by NCCT as 40 hours per week). Each employer may only verify work experience performed at their own facility.

The applicant successfully performed the skills attested to through: ____ employment experience ____ educational training

from _____ / _____ through _____ / _____ or ____ present.
month *year* *month* *year*

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***). Your signature and legible contact information are required for valid completion of this form.

Today's Date: (mm/dd/yyyy) _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Title _____

Supervisor/Verifier Printed Name _____

Supervisor/Verifier Signature _____

Company Name _____

Company Address _____ City, State _____ Zip _____

Business Phone _____ Business Email _____

Note: The Supervisor that signs this document must be able to be contacted.

Note: This page may be photocopied if more than one employer or direct patient supervisor will be verifying cases and providing documentation.