ALLIED HEALTH SPECIALTY SHEET

Cytotechnologist

Please list any limitations or comments you may have on a separate sheet.

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname
	Social Security Number			

LICENSES *List all states in which you are or have ever been licensed*	Original State License	License Number	Exp. Date	State License	License Number	Exp. Date
	State License	License Number	Exp. Date	State License	License Number	Exp. Date

CERTIFICATION

ASCP Registry #: ____________________ Year: ____________________

Other (Please specify): ____________________

CLINICAL SKILLS

Please check the areas below where you have clinical experience in the past 24 months and where you are currently proficient.

Interpretive Skills

- ☐ Pap (GYN)
  - ☐ Conventional
  - ☐ Thin-prep
  - ☐ Autocyte
- ☐ Non-GYN
  - ☐ Bronchs
  - ☐ Sputa
  - ☐ BAL
  - ☐ Body fluids
- ☐ FNA
  - ☐ General
  - ☐ Breast
  - ☐ Lung
  - ☐ Nodes
  - ☐ Other: ____________________

Other Skills

- ☐ Computer literacy
- ☐ Automated equipment
- ☐ Cytospin

Please list any additional capabilities you have that are not listed above: ____________________

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I affirm that all information given on this page is true and accurate. **Initials** ________ **Date** ________

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