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 for laboratory personnel should complete this application.

3. All programs must submit supporting documents.

COMPLETING THE APPLICATION:

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 Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.**

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**
   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. **Program Director (include current resume or curriculum vitae)**

5. **Clinical Training Program**
   Name of laboratory
   Address
   Type of laboratory
   Telephone number
   Hospital or laboratory contact person
   AHCA license number (if Florida licensed)
   CLIA certification

6. **NAACLS, CAAHEP, or ABHES accreditation documentation**

7. **Board** Approved **Training Program**
   For programs that were Board approved but not nationally accredited, in addition to the items listed in numbers 1-5 above, the program shall provide the following information:
   Curriculum outline including the numbers of lecture hours and clinical hours
   National certification examination pass rates, program completion rates, graduate placement rates and graduate employment survey results for the three (3) years prior to the date of submitting the renewal application.

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(Client 6603); (xact 2020)

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(850) 245-4355
http://www.floridasclinicallabs.gov/

APPLICATION CATEGORY:

O (xact 2020) Renewal – License Fee	$300.00
TOTAL:	**$300.00**

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

PROFILE DATA: (Please print or type)

1. **PROGRAM NAME:** _____

TP# _____

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

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 SPECIALTY:

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

2. TRAINING DATA:

a. Do you offer HIV/AIDS, Medical Errors and Florida laws and rules education? [ ] YES [ ] NO

b. Name of Program Director responsible for oversight of training program (attach current resume or curriculum vitae):

_____

(Last) (First)

c. Name of Training Coordinator, if different from Program Director (attach resume or curriculum vitae):

_____

(Last) (First)

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

a. Accredited Programs:

- **Personnel/Faculty roster, include license number and level**
- **Student Roster** (program start and anticipated graduation date)

b. Nonaccredited Programs:

- **Personnel/Instructors Roster** (Attach personnel/faculty roster, include license number and level of licensure)
- **Student Roster** (program start and anticipated graduation date)
- **Attrition Rates**
- **Pass rates on national certification examinations**
- **Graduate placement rates**
- **Graduate employment survey results**

CLINICAL AFFILIATE LIST

(only if College/University based program)

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:_____