Laboratory Education Program Director
Certification of Educational and Clinical Requirements

I certify that _____ completed/will complete the
(Name of applicant)

educational and clinical requirements for the _____ category of
(MT, MLT, or Specialist)

licensure on _____ and is eligible to take a board
(Date degree granted/ to be granted)

recognized national certifying examination.

_____ _____
Program Director signature Date

_____ _____
Print name of Program Director Phone number of Program Director

_____
Program Director address

_____
Program Director e-mail address

Program Director may submit completed form to:
ndbclp@aptnd.com
NDBCLP
PO Box 4103
Bismarck, ND 58502-4103