

**APPLICATION FORM FOR
MEDICAL LABORATORY ASSISTANTS/TECHNICIANS
CERTIFICATION EXAMINATION - rev. Nov. 2007**

Please print: FIRST NAME
Ms./Miss/Mrs./Mr.

LAST NAME

***IF YOUR NAME IS DIFFERENT FROM THE NAME ON ENCLOSED DOCUMENTS PLEASE PROVIDE AN EXPLANATION AND VALIDATE CURRENT NAME WITH A PHOTOCOPY OF A PASSPORT OR CURRENT DRIVER'S LICENSE SHOWING THE NAME AS YOU NOW USE**

MAILING ADDRESS: STREET

APT/UNIT #

CITY/TOWN

PROVINCE

POSTAL CODE

PHONE NO. (home) (____) (____) (bus.) (____) (____)

Application Status:

- A - Student** - Currently enrolled in an OSMT approved training program
- B - Graduate** - Completed diploma course **within last (5) years (diploma attached)**
- C - Special Consideration** - Applicants who do not meet one of the above criteria may submit an application under special consideration status. The application must be accompanied by: **1)** a resume, **2)** a letter from your employer stating position held, length of time in the position, and a list of duties performed, **3)** the Canadian Experience Verification Form completed and signed by your supervisor, **4)** an academic credentials assessment report, and **5)** a copy of a diploma/degree from the highest level of education received in the science field.

FOR OSMT OFFICE USE ONLY	EXAM ID No. _____
Dates: this application received on _____	
application fee received on _____	
examination fee received on _____	
missing document(s) _____	
<input type="checkbox"/> APPROVED <input type="checkbox"/> CONDITIONALLY APPROVED <input type="checkbox"/> INCOMPLETE <input type="checkbox"/> REJECTED	
Reasons: _____	

SIGNATURE _____	DATE _____

CATEGORY C - SPECIAL CONSIDERATION

EDUCATION SUMMARY - complete information for your highest level of education.

NAME OF TRAINING INSTITUTION

CITY/TOWN/AND CAMPUS LOCATION

PROVINCE/COUNTRY

ATTENDED: FROM _____ TO _____
MONTH/YEAR MONTH/YEAR

COMPLETED: _____
PROGRAM OR GRADE

- *Proof of program completion will be required - must submit a copy of the diploma
- *Foreign trained applicants must submit an Academic Credentials Assessment letter
- *Candidates must complete the Canadian Experience Verification Form included with this application

EMPLOYMENT SUMMARY (experience in the health sciences field only)

NAME OF MOST RECENT EMPLOYER

POSITION

CITY/TOWN

PROVINCE

WORKED: PART-TIME FROM _____ TO _____
MONTH/YEAR MONTH/YEAR

WORKED: FULL-TIME FROM _____ TO _____
MONTH/YEAR MONTH/YEAR

* Proof of employment must be provided on company letterhead

ALL APPLICANTS TO COMPLETE AND SIGN BELOW

Have you applied to write the OSMT MLA/T Certification examination previously?

NO YES, which year(s) _____

Have you written the OSMT MLA/T Certification examination previously?

NO YES, which year(s) _____

I certify that the above information contained herein is true and correct.

SIGNATURE

DATE

Set application fee of \$65.00 plus GST (\$68.25 non-refundable). DEADLINE FOR RECEIPT OF APPLICATION IS **February 15, 2008** or closest business day.

Set examination fee of \$150.00 plus GST (\$157.50) is payable upon receipt of notification of approval. DEADLINE FOR RECEIPT OF EXAMINATION FEE IS **April 18, 2008** or closest business day. **Please note that photo identification will be required at the examination site.**

Request to Withdraw must be made by in writing by **May 9, 2008** in order to receive a refund. A \$40 administrative fee will apply.

POST-DATED CHEQUES ARE NOT ACCEPTABLE. Make cheques or money orders payable to the OSMT and forward with your application and documentations to:

**Ontario Society of Medical Technologists
234 Eglinton Ave E., Suite 402
Toronto, ON M4P 1K5**

Direct any questions/enquiries to: (416) 485-6768 / 1-800-461-6768

Fax: (416) 485-7660

E-mail: osmt@osmt.org

Web Site: www.osmt.org

**USE THIS FORM TO PAY YOUR APPLICATION FEE
BY CREDIT CARD FOR THE 2008 OSMT
CERTIFICATION EXAMINATION FOR
MEDICAL LABORATORY ASSISTANTS/TECHNICIANS.**

APPLICANT NAME: _____

Please charge the 2008 Application Fee of \$68.25 (\$65 plus GST) to:

Card Number _____ **VISA** _____

Cardholder Name _____ **MasterCard** _____

Valid from _____ **Expiry date** _____

Cardholder Signature _____

Do not staple to your application. If credit card is being used to pay for more than one application, make a copy of this form and complete separately for each application.

Office use only: Entry Date _____ Authorization # _____

**Canadian Experience Verification Form
(for Special Consideration Applicants Only)**

Verification of Canadian Experience
(form to be completed by supervisor/employer)

This is to certify that _____ has:
(print applicant's name)

A. completed _____ successful phlebotomy procedures. (minimum requirement: 20)

Supervisor's Name & Position (please print)

Phone Number

Signature

Institution

B. completed _____ successful ECG procedures. (minimum requirement: 10)

Supervisor's Name & Position (please print)

Phone Number

Signature

Institution

C. completed _____ hours of practical experience in a medical testing facility.
(minimum requirement: 80 hours)

Supervisor's Name & Position (please print)

Phone Number

Signature

Institution