

THE INTERNATIONAL BOARD OF BLOOD MANAGEMENT

APPLICATION FOR RECERTIFICATION

This application is available to individuals who have previously been certified and are currently performing techniques of clinical autotransfusion and cell processing in the perioperative environment. Recertification Application fee is \$100 (Payable to AmSECT). **Recertification Application fee is non-refundable.**

All information MUST be typed; handwritten information will not be accepted.

Name:

Credentials:

Address Line 1:

Address Line 2:

City:

State:

Zip/Postal Code:

Country:

E-Mail:

Home Phone:

Work Phone:

Ext.

Date of Birth:

Social Security #:

EMPLOYMENT

Employer:

Address Line 1:

Address Line 2:

City:

State:

Zip/Postal Code:

Country:

Supervisor:

Work Phone:

Ext.

Fax:

E-Mail:

FACILITIES

Please provide information for all facilities where clinical cases are performed.

1. Hospital/Clinic Name:
Address Line 1:
Address Line 2:
City:
Zip/Postal Code:
Country:

State:

Confirming Individual
Name:
Title:
Phone:

2. Hospital/Clinic Name:
Address Line 1:
Address Line 2:
City:
Zip/Postal Code:
Country:

State:

Confirming Individual
Name:
Title:
Phone:

3. Hospital/Clinic Name:
Address Line 1:
Address Line 2:
City:
Zip/Postal Code:
Country:

State:

Confirming Individual
Name:
Title:
Phone:

4. Hospital/Clinic Name:
Address Line 1:
Address Line 2:
City: State:
Zip/Postal Code:
Country:

Confirming Individual
Name:
Title:
Phone:

5. Hospital/Clinic Name:
Address Line 1:
Address Line 2:
City: State:
Zip/Postal Code:
Country:

Confirming Individual
Name:
Title:
Phone:

6. Hospital/Clinic Name:
Address Line 1:
Address Line 2:
City: State:
Zip/Postal Code:
Country:

Confirming Individual
Name:
Title:
Phone:
Email:

CLINICAL ACTIVITY REPORT

Please provide documentation of fifty (50) cases in autotransfusion or cell processing performed between January 1st of previous year to December 31st of previous year:

	HOSPITAL/CLINIC	DATE	PROCEDURE	SURGEON
1				
2				
3				
4				
5				
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This page **MUST** be signed by the applicant and an immediate supervisor or other hospital authority.

Authorization for Release of Information

This section **MUST** be signed by the applicant.

I certify that all information submitted in this report is accurate and correct. Any misrepresentation of the information will result in a revocation of the application or a termination in certification by the International Board of Blood Management. I hereby authorize the Immediate Supervisor or other Hospital Authority to verify the accuracy of the information on the submitted Clinical Activity Report.

Signature: _____

Printed Name: _____

Date: _____

Case Verification

This section **MUST** be signed by an immediate supervisor or other hospital authority.

FOR USE BY IMMEDIATE SUPERVISOR OR OTHER HOSPITAL AUTHORITY ONLY

Cases verified: _____ Cases not verified: _____

Reasons for lack of verification:

Signature: _____

Title: _____

Hospital or Company: _____

Address: _____

Date: _____