



BRITISH COLUMBIA SOCIETY OF LABORATORY SCIENCE
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2009 APPLICATION FORM CERTIFICATION OF MEDICAL LABORATORY ASSISTANT

Please supply all information and documentation as requested, attaching a separate sheet of paper (if necessary). Please PRINT THE FOLLOWING INFORMATION.

Last Name	Mr/Ms/Mrs	
Previous Last Name?		
First Name		
Address		
City		
Postal Code		
Phone	Home	Work
Email		
Employer		
Work address		

GRADUATES OF MEDICAL LABORATORY ASSISTANT PROGRAMS:

****Submit copy of Diploma/Certificate with your application.**

Further documentation may be required

Name of Institution: _____

Address: _____

Note: See Certification Information Package for BCSLS approved programs. Programs that are not listed may qualify after review on an individual basis. Specific documentation will be required from these institutions before approval.

BCSLS collects personal information for membership record purposes. We use your personal data to keep you informed of BCSLS activities and professional issues. We do not provide members' personal information to other organizations.

FOR BCSLS OFFICE USE:

Received:

Processed:

Approved:

Entered:

Record of CANADIAN MEDICAL LABORATORY EMPLOYMENT:

Employer, Address, Phone Number	Contact name	Employment period
1.		
2.		

FEE SCHEDULE

When you choose to join BCSLS at the same time as you apply for certification, you are eligible for a reduced membership rate – including professional liability insurance.

BCSLS CERTIFICATION APPLICATION FEE: **\$78.75** (one time only non-refundable)

BCSLS MEMBERSHIP Special Offer Fee: **\$56.25** (*expires Apr. 30/10)
\$135.00

(a reduced rate for NEW members only at time of certification.*

Prices include GST (Registration # 12696 1630)

I hereby certify that the information given on this form is correct and complete.

 Applicant's signature

 Date

AMOUNT SUBMITTED WITH ORDER \$ _____

We accept Cheques, Money Orders, Visa, and MasterCard (credit card can be used for online registration or by writing your information below)

Credit card # _____ **Expiry Date:** _____

Name on card: _____

Billing Address: _____
