

2010 IBBM CERTIFICATION APPLICATION FOR THE PERIOPERATIVE BLOOD MANAGEMENT TECHNOLOGIST EXAMINATION

I. ELIGIBILITY CRITERIA

The applicant must fulfill the following criteria to be eligible for the PBMT Examination:

- a. The applicant must have a minimum of a high school diploma or equivalent
- b. Be practicing in the field of blood management for a minimum of one (1) year completing a yearly minimum of fifty (50) autotransfusion procedures (those involving a semiautomatic cell processing/washing device) with a total of fifty (50) procedures, with evidence thereof.
- c. Evidence of the clinical location(s) (hospital name and address), procedure type, and date performed.
- d. The applicant must have submitted a completed application for examination on file with the IBBM office thirty (30) days prior to the date of examination.

II. APPLICATION INSTRUCTIONS

Individuals who wish to apply for certification must complete, sign, and file with the IBBM office the corresponding certification application, together with the supporting data required by the application. Incomplete applications cannot be accepted for review by the IBBM and will be held until all documentation is submitted.

DEADLINES & FEES

Applications will be accepted on the following filing schedule:

Deadline: Thirty (30) days before scheduled examination.

Fee: \$200.00

A completed application form must be submitted by certified mail and postmarked no later than 30 days before the scheduled examination. Application and application fee must be submitted together.

The completed certification application and a copy of any one Clinical Credentialing (CCP, RN, LPN, MD, etc.) or a copy of High School or College Diploma must be certified mailed to the IBBM National Office. Documents must be postmarked on or before 30 days before the scheduled examination.

Applications for which all parts are not postmarked 30 days before the scheduled examination will not be accepted for consideration and will be returned to the candidate unprocessed.

A. GENERAL INFORMATION

Name of Applicant _____
Last Name First Middle

Degrees/Credentials _____

Date of Birth ____ - ____ - ____

Address (to be used for ALL mailings related to certification)

Organization _____

Mailing Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Home Phone _____

B. SECONDARY EDUCATION

High School _____

Date of Graduation _____

City _____ State _____ Zip _____

C. POST SECONDARY EDUCATION

College/University _____

Date of Graduation _____

City _____ State _____ Zip _____

D. EMPLOYMENT

Employer _____

Mailing Address _____

City _____ State _____ Zip _____

Supervisor must be same individual listed on Authorization for Release of Information and Case Verification Form

Supervisor _____

Phone _____ Fax _____ Email _____

E. FACILITY APPOINTMENTS

Please list all facilities where you are appointed. List must include all facilities referenced in Clinical Activity Report.

NAME OF HOSPITAL	ADDRESS OF HOSPITAL	CONFIRMING INDIVIDUAL AT FACILITY	CONTACT INFORMATION OF CONFIRMING INDIVIDUAL
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:
		Name: Title:	Ph: Fax: Email:

F. CLINICAL ACTIVITY REPORT

Please provide documentation of fifty (50) cases in autotransfusion or cell processing performed from January 1st to December 31st of previous year. Procedures must be specific (Total Hip Arthroplasty, Posterior Spinal Fusion, etc.).
Procedure categories will not be accepted (ORTHO, VASCULAR, EMERGENCY, HEART, etc.).

	FACILITY	DATE	PROCEDURE	SURGEON
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G. AUTHORIZATION FOR RELEASE OF INFORMATION AND CASE VERIFICATION FORM & CREDENTIALS

AUTHORIZATION FOR RELEASE OF INFORMATION AND CASE VERIFICATION FORM

The Authorization for Release of Information and Case Verification Form must be completed, signed by applicant and immediate supervisor or other hospital authority. Immediate supervisor or other hospital authority must verify all 50 clinical cases submitted with application.

CREDENTIALS

A copy of any one Clinical Credential held by applicant must be submitted. If applicant holds no Clinical Credential, a copy of applicant's High School Diploma or College Diploma must be submitted. Acceptable Clinical Credentials are: CCP, RN, LPN, MD, etc.

H. CHECKLIST

MATERIAL TO BE SUBMITTED

An application will be considered complete only when all supporting paperwork required by the application has been submitted to IBBM. Incomplete applications will not be processed. For an applicant to be eligible for the exam, the complete application must be submitted by the registration deadline.

An application will be considered complete provided that all of the following materials have been submitted:

1. Application with all pages completed.
2. Copy of Clinical Credentialing or copy of High School or College Diploma enclosed with application.
3. Full payment of the application fee.

I. REVIEW PROCESS AND SCHEDULE

IBBM will review all applications which are complete and postmarked by the deadline. All applicants will be notified of eligibility two weeks prior to examination.

**INTERNATIONAL BOARD OF BLOOD MANAGEMENT
AUTHORIZATION FOR RELEASE OF INFORMATION
AND CASE VERIFICATION FORM**

AUTHORIZATION FOR RELEASE OF INFORMATION

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

FOR USE BY IMMEDIATE SUPERVISOR OR OTHER HOSPITAL AUTHORITY ONLY

Number of Cases verified: _____ Number of Cases not verified: _____

Reasons for lack of verification:

Signature: _____

Title: _____

Hospital or Company: _____

Address: _____

Date: _____