



**PATHOLOGIST'S ASSISTANT
APPLICATION & CHECKLIST**

Division of Public and Behavioral Health

727 Fairview Drive, Suite E

Carson City, Nevada 89701

Phone: (775) 684-1030 Fax: (775) 684-1075

Website: <http://dpbh.nv.gov/Reg/RegulatoryPgms/>

THIS BOX FOR OFFICAL USE ONLY

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COMPLETE THIS FORM. PLEASE FILL IN THIS FORM ELECTRONICALLY, PRINT, SIGN, DATE AND SUBMIT. *(If unable to complete electronically type or print in black or blue ink and submit)*

INCOMPLETE APPLICATIONS WILL DELAY PROCESSING OF YOUR CERTIFICATE

INDICATE APPLICATION TYPE. *(Check only one):*

Initial Certificate

Reactivation of Certificate

PERSONAL INFORMATION
Name
Maiden/Previous Name (if applicable)
Social Security Number (REQUIRED)
Date of Birth
Email Address
Mailing Address (MUST BE HOME ADDRESS or PO BOX)
City, State
Zip Code
Phone Number

COMPLETE ALL SECTIONS

(Regulations governing medical laboratories and laboratory personnel may be found at:

<http://leg.state.nv.us/NAC/NAC-652.html>)

Application Attestations *(Check if applicable)*

If you do not provide a method of electronic communication, such as an e-mail address or any other method by which to communicate with you other than by telephone or U.S. mail, you must check this box attesting that this is not feasible and acknowledging that the U.S. mail is the only means which to communicate with you.

Child Support Information: (Must check one box)

- I am not subject to a court order for the support of a child.
- I am subject to a court order for the support of one or more children and am in compliance with the order or with a plan approved by the district attorney or other public agency enforcing the order for repayment of the amount owed pursuant to the order.
- I am subject to a court order for the support of one or more children and I am not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order. You are required to contact the district attorney or other public agency enforcing the order to determine the actions that you may take to satisfy the arrearage.
 - ❖ Your application **will be denied** if you do not complete this section.

Certified in Nevada (laboratory personnel) (Indicate Yes or No)

Do you currently hold a Nevada laboratory personnel certificate? Yes No

If yes, provide your certification number here: _____ Type: _____

INITIAL APPLICANTS COMPLETE THIS SECTION

Initial Applicants must submit the information in Option 1 or Option 2 below

Option 1 (if selecting Option 1 you **MUST** check box)

I have included a copy of my certification of completion of a training program approved by the American Association of Pathologists' Assistants.

Option 2 (if selecting Option 2 you **MUST** check **both** boxes)

- I have included sealed transcripts sent from the college/university in which I obtained a baccalaureate degree with a major or minor in a biological science or an allied health field.
- I have included proof which shows I have at least 3 years of combined experience in surgical pathology and autopsy pathology such as a signed, dated letter on letterhead from the laboratory(s) from which I obtained my experience.

Foreign educated applicants ONLY: (MUST have your Bachelor's degree evaluated)

I have included my evaluation for foreign studies from one of the National Association of Credential Services (NACES) members found at the following link: <http://www.naces.org/>

IF YOU ARE APPLYING FOR A REACTIVATION OF A CERTIFICATE YOU MUST COMPLETE THIS SECTION

(Must check both boxes)

- I have submitted with my application copies of my CEU certificates which add up to 10 CEU contact hours.
- I certify it has been 5 years or less since my certification has expired.

Note: If it has been more than 5 years since your certification has expired you must apply as an Initial Applicant by completing the initial applicant's section.

Previous Certification Number: _____

Expiration Date: _____

I understand that knowingly making a false statement on this application will be cause for denial, suspension, or revocation of licensure. I have examined this application and it is complete. I declare under penalty of perjury that the foregoing is true and correct.

Executed on:

Applicant's Signature: _____ Date: _____

ALL APPLICANTS MUST SUBMIT, WITH YOUR APPLICATION, TO THE ADDRESS PROVIDED BELOW:

- A completed, signed **and** dated application.
- A **\$113** fee via personal check, cashier's check or money order **paid to the order of Nevada State Treasurer.**

Notes:

- ❖ Where letters are required, if it takes more than one letter to show you have the required years of experience please include all letters needed.
- ❖ Certificate issued is valid for two (2) years after the date on which it was issued.
- ❖ You may work as a temporary employee for a period not exceeding 6 months while the application is being processed.
- ❖ It is your responsibility to renew your certification before it expires, regardless of whether you receive a renewal notification or not.
- ❖ Allow up to six months processing time.
- ❖ If insufficient funds are submitted a \$25 fee will be assessed.

Submit completed application, including all requested documentation and fee to:

Division of Public and Behavioral Health
Medical Laboratory Services
727 Fairview Drive, Suite E
Carson City, NV 89701

If you have any questions please contact 775-684-1030 and request Medical Laboratory Services.

Change of Information

You must notify the Division of any change to the information contained in your application within 30 days after the change by completing and submitting the Change of Name or Address Form for Clinical Laboratory Personnel found at:

<http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Reg/MedicalLabs/Docs/Applications/changeofaddress.pdf> Failure to comply with this requirement is grounds for denial of your application or the suspension or revocation of your license, as applicable.