APPLICATION FOR A CENTER OF EXCELLENCE IN LABORATORY LEARNING

FACILITY / APPLICANT INFORMATION			
Practice Name:			
Physicians:			
Current Address:			
City:	State:	Country	ZIP Code:

EMBRYOLOGIST EMPLOYMENT OVERVIEW
How many on-site Embryologists do you employ in your practice? _____
How many off-site Embryologists do you employ in your practice? _____

DETAILED EMBRYOLOGIST DATA: PLEASE INCLUDE NAME AND DEGREE, YEARS IN EMBRYOLOGY, AND YEARS WORKING IN YOUR PRACTICE (PLEASE ADD PAGES IF NEEDED)			
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
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Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:
Name:	Title:	Yrs in RE:	Yrs:

COURSE COMPLETION INFORMATION		
Please list the Embryologists who have successfully completed the Embryology Certificate Course through ASRM:		

RENEWAL WILL BE REQUIRED EVERY 3 YEARS

AUTHORIZATION AND SIGNATURE	
I authorize the verification of the information provided on this form. I have discussed this information with my embryology staff and have permission to share their information with ASRM. I have made a copy of this application prior to submitting.	
Printed Name of applicant:	Title:
Signature of applicant:	Date:

Below For Internal Verification Only		
#Eligible:	#Passed Course:	Percentage:
Approved?	Notified:	Date of Review:
US programs: Active, non-provisional SART member?		