**L**ouisiana **S**tate **B**oard of **M**edical **E**xaminers

630 Camp Street, New Orleans, LA 70130

(504) 568-6820

**Clinical Laboratory Personnel**

**Initial Licensure Application**

**READ CAREFULLY AND TAKE NOTICE:** This application and any subsequently issued license, permit, certificate, or other authority to practice in the State of Louisiana are subject to all Louisiana laws and administrative rules governing the practice of medicine and allied health. A copy of the laws and rules can be found on the LSBME website. All applicants are hereby PLACED ON NOTICE that they are responsible for knowing the laws and rules and for complying with them. By submitting this application, you expressly acknowledge and agree that you are responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which you are applying.

|  |  |
| --- | --- |
| **Licensure Category - Check one of the following:**  CLS Generalist  CLS Specialist  CLS Technician  Cytotechnologist  Laboratory Assistant  Phlebotomist | **Licensure Type - Check one of the following:**  Full  Temporary  Trainee  **Licensure Status - Check one of the following:**  Initial license  Reinstatement |

**FILL IN ONLINE PRIOR TO PRINTING**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: First | | | | Middle | | Last | | | | Suffix (Jr, Sr) |
| List all other names under which you have ever been known: | | | | | | | | | | |
| Social Security Number | | | Driver’s License Number and State | | | | | E-mail Address | | |
| Marital Status | | | Spouse’s Full Name | | | | | Cell Phone # | | |
| Sex | Height | Weight | | Eyes | Hair | | Race | | Physical Marks | |

**ADDRESSES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Home Address  (mailing) | Street & Number | | | City | State |
| Zip | Parish (if in LA) | | Telephone (area code) |  |
| Preferred Mailing  (if other than above) | Street & Number | | | City | State |
| Zip | | Parish (if in LA) | Telephone (area code) |  |
| Business Address  Public Address  (will be posted on  LSBME website) | Name of Business | | | | |
| Street & Number | | | City | State |
| Zip | | Parish (if in LA) | Telephone (area code) |  |

**BIRTH/LEGAL AUTHORITY TO WORK IN THE U.S.**

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| --- | --- | --- | --- |
| Date of Birth | Place (City/State/Country) | | Are you a U.S. citizen? |
| If not a native born U.S. citizen, provide the following information: | | | |
| If naturalized: Certificate number | | INS number | |
| Petition number | Date issued | District court through which issued | |
| If immigrant: Type of Visa | | | |

**MILITARY SERVICE**

|  |  |  |  |
| --- | --- | --- | --- |
| U.S. Active Duty  Yes No | Branch | Dates Served | Type of Discharge |

**EDUCATION** Copy this page if more space is needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| High School | | College/University | | |
| City, State | | City, State | | |
| Mo/Yr Started | Mo/Yr Graduated | Mo/Yr Started | Mo/Yr Ended | Degree Earned |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| College/University | | | College/University | | |
| City, State | | | City, State | | |
| Mo/Yr Started | Mo/Yr Ended | Degree Earned | Mo/Yr Started | Mo/Yr Ended | Degree Earned |

**WORK HISTORY and NON PROFESSIONAL ACTIVITY** Copy this page if more space is needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Account for all time for the ten years preceding your application including any periods of unemployment** | | | | |
| From  Month/Year | To  Month/Year | Location  City/State | Employer | Job Title |
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**CERTIFICATION**

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| --- | --- | --- | --- |
| List date and result of each exam attempt. Failures must be disclosed. Scores must be sent from certifying agency directly to LSBME. | | | |
| Date | Result - Pass/Fail | Expected exam date (if recent graduate) | Name of Certifying Agency |
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**OTHER LOUISIANA LICENSES**

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| --- |
| Have you ever held a healthcare related license in the State of Louisiana? Yes No. |
| If yes, what type of license  License # |

**OTHER STATE LICENSES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever held a healthcare related license (permit, or certification, permanent or temporary) in any other state? Yes No | | | | |
| If yes, provide information listed below. Attach separate page if necessary. Verification of each health care related license is required | | | | |
| State | Type of License | License # | Issue Date | Expiration Date |
|  |  |  |  |  |
|  |  |  |  |  |
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By signing this document, I certify that all information on this form is truthful and authentic.

Printed Name:  Social Security #:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

What is your preferred method of written communication? E-Mail Address Mailing Address

**By submitting this application, I expressly acknowledge that I understand and agree I am responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which I am applying. A copy of which are available for my review on the LSBME website.** [**CLICK HERE TO READ THE RULES BY SELECTING YOUR LICENSE CATEGORY**](https://www.lsbme.la.gov/licensure/rules)**.**