



Washington State Department of  
**Health**  
 Medical Assistant Credentialing  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Phlebotomist Training Attestation

Complete this form if you completed a phlebotomy training program supervised by a Washington State licensed healthcare practitioner as defined under [RCW.18.360.010\(3\)](#). The healthcare practitioner who supervised the phlebotomy training program must sign and date this as proof of completion.

### Applicant's Demographics:

First Name	Middle	Last Name
Credential # (If available)	Date of Birth	
Address		
City	State	Zip Code

### Washington State Licensed Supervising Healthcare Practitioner Attestation:

The medical assistant-phlebotomist shall receive training, evaluation(s), and assessment of knowledge skills to determine minimum level competency.

I, \_\_\_\_\_ certify that \_\_\_\_\_  
 (Phlebotomy training program's supervising healthcare practitioner) (Medical-assistant phlebotomist name)  
 completed training as required by [WAC 246-827-0400\(2\)](#).

\_\_\_\_\_  
 Signature of health care practitioner Date (mm/dd/yyyy)

\_\_\_\_\_  
 License Number Expiration Date (mm/dd/yyyy)

**Submit completed form with original signatures to the address above.**