

Packaging and Shipping Workshop Application

****Please complete a separate application for each applicant and for each workshop. ****

Name of Applicant: _____
(Please **PRINT** full name **LEGIBLY** for continuing education certificate)

Date/Location of Workshop: (See NCSLPH website) _____

****Note: Refer to "Training Workshops" on NCSLPH website for descriptions, dates and deadlines. ****

**Please check whether you are taking this course for:
INITIAL CERTIFICATION
RECERTIFICATION (Date of previous certification)

Organization/Facility _____

Street or Box Number _____

City _____ State _____ Zip _____

Phone # (work) : (_____) _____ Ext. _____ Fax (_____) _____

(Please ensure the e-mail addresses below are accurate and legible.)

Supervisor E-Mail address _____

Applicant E-Mail Address _____

Certification/Licensure

Clinical: MT RN/LPN/FNP MOA Other

Job Title: _____

Job Duties: (as related to the workshop applied for) _____

Signature of Applicant

Signature of Applicant's Supervisor

Circumstances may limit acceptance to one person per lab. If two or more apply, supervisor must indicate 1st, 2nd, etc. choice for acceptance. _____

MAIL OR FAX COMPLETED APPLICATION AND CHECKS TO:
North Carolina State Laboratory of Public Health
Attn: Laboratory Improvement Unit
1918 Mail Service Center
Raleigh, NC 27699-1918
Ph: 919-733-7186 Fax: 919-715-9243

