AMERICAN CERTIFICATION AGENCY
FOR HEALTCARE PROFESSIONALS

P.O. BOX 58
OSCEOLA, IN 46561
TEL: (574) 277-4538
Fax: (574) 277-4624

Application for Certification as a
CERTIFIED PATIENT CARE TECHNICIAN – CPCT(ACA)

Print or type your name exactly as you want it to be on your certificate.

Last Name	**First Name**	**Middle Initial/Name**

Information and Instructions to Applicant

1. Please type or print all information **except** where signatures are required.
2. Please check eligibility requirements for certification on the next page.
3. Before submitting this application, make sure you have provided the following:
   - **a.** _____ $100.00 Application fee (must accompany the application or it will not be processed)
   - **b.** _____ Proof of high school graduation or equivalent
   - **c.** _____ If applicable, official final transcript stating graduation from college or training program
   - **d.** _____ If applicable, copy of state license
   - **e.** _____ Application signed and dated by applicant and necessary instructors and supervisors
4. Application must be completed, signed and received at least 15 days before the scheduled examination date.
5. All applications are subject to content verification and approval.
6. Ineligible applicants will be refunded the examination fee minus a $35.00 processing fee.
7. No refunds will be made for no-shows on the exam date.
8. You will receive notification upon approval of this application, informed of scheduled examination site, receive study guide and content outline.

ELIGIBILITY REQUIREMENTS FOR CERTIFICATION

1. Applicant shall be a graduate of an accredited high school or acceptable equivalent.
2. Applicant must meet one of the following requirements (check one box):
   a. ☐ Completed at least one year of work experience using patient care, ECG and phlebotomy skills.
   b. ☐ Successful completion of a formal program (e.g. nurse aide or equivalent, home health aide, etc.) which included didactic instruction in patient care, ECG and phlebotomy and a clinical experience.
   c. ☐ Successful completion of a formal patient care technician or equivalent program.
3. All applicants applying under 2a and 2b **must** take and **pass** the ACA examination for Certified Patient Care Technician CPCT.

Part I. PERSONAL INFORMATION

Full Name _____ Social Security Number: ___/___/___

Street Address _____ City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____

Email Address: _____

Part II. EDUCATION AND TRAINING

A. Secondary

Senior High School _____ Dates Attended _____

Address _____ Date Graduated _____

G.E.D. _____ Date _____ City/State _____

B. College or University

Name/Complete Address	Dates	Hours Competed	Degree

C. Training (Specify Type)

If applicant is currently in school or training program, this section must be completed by proper school official to verify training and successful completion of the course. The applicant's transcript must be provided.

Applicant Name _____ Birth Date _____

School Name _____

Program Name _____ Tel. No. _____

School Address _____

Course Dates: From ____/____/____ To ____/____/____

I hereby certify that the applicant named above did (or will) satisfactorily complete the entire formal program which included didactic instruction. I recommend this applicant as a qualified candidate for certification as a Certified Patient Care Technician of the American Certification Agency.

Official Signature _____ **Date** _____

Title/Position _____

Part III EMPLOYMENT EXPERIENCE

Approved ECG Experience

All Patient Care, ECG and Phlebotomy experience credited towards certification must be earned in an approved healthcare facility such as a hospital, physician office laboratory, independent laboratory, HMO, group practice, etc.

1. Facility _____ Employment Dates (Mo & Yr)

   Address _____ From ____/____ To ____/____

   Position Held _____ Supervisor Name _____ Phone _____

2. Facility _____ Employment Dates (Mo & Yr)

   Address _____ From ____/____ To ____/____

   Position Held _____ Supervisor Name _____ Phone _____

3. Facility _____ Employment Dates (Mo & Yr)

   Address _____ From ____/____ To ____/____

   Position Held _____ Supervisor Name _____ Phone _____

Part IV. RECOMMENDATION FOR CERTIFICATION

If applicant is currently employed, please have supervisor or manager sign this recommendation for certification.

Signature/Title _____ **Date** _____

Address _____

Street **City** **State** **Zip**

Part V. OPTIONAL SCORE RELEASE

Some educational institutions and/or state licensure boards request applicants' examination results. To grant permission for your results to be eligible for release if requested, sign the release authorization below. Signing this release is VOLUNTARY and will not effect the outcome of your examination in any way. If you DO NOT want your results released, DO NOT SIGN THE AUTHORIZATION. I hereby authorize the American Certification Agency for Healthcare Professionals to release my examination scores:

Applicant's Signature _____ **Date** _____

Part VI. AGREEMENT

I hereby give my authorization to the American Certification Agency for Healthcare Professionals to request necessary information from individuals, institutions, and/or organizations named herein to validate information for certification. I certify that the information given herein is true and correct, to my knowledge and belief, and realize that certification is subject to revocation for misrepresentation. If accepted as a certificant, I agree to uphold and abide by the Standards of Practice and Bylaws of American Certification Agency for Healthcare Professionals.

Applicant's Signature _____ **Date** _____

Do not write in space below

Date application received _____ Date Completed _____ Approved by _____

Application rejected by _____ Reason _____ Date notified _____

Exam Date	Test Series	Exam Site	Proctor	Exam Score	Fee Paid

Birth Date: _____ **Social Security Number** _____

Granted Certificate # _____ **Issue Date** _____

Recert. Dates _____