The Benchmark in Allied Healthcare Certification

RESCHEDULE APPLICATION

❑ EXAM ❑ WORKSHOP

First Name	Middle Initial(s) *if any*	Last Name
Address:		Apt #:
City:	State:	Zip Code:
Telephone Number(s): (day)	(eve)	(cell) *optional*
Social Security #:	Email Address:	
Date of Last Exam/Workshop: *(mm/dd/yy)*	Reschedule Date: *(mm/dd/yy)*	

Exam/Workshop You're Rescheduling: ***(please check one)***

- ☐ CPT= Certified Phlebotomy Technician
- ☐ CCMA = Certified Clinical Medical Asst.
- ☐ CMLA = Certified Medical Lab. Asst.
- ☐ CPT/CET = Certified Phlebotomy Tech Certified EKG Tech.
- ☐ CET = Certified EKG Technician
- ☐ CPCA = Certified Patient Care Assoc.
- ☐ CPhT = Certified Pharmacy Technician
- ☐ CORST = Certified Operating Room Surgical Technician
- ☐ CMHT = Certified Mental Health Technician
- ☐ CMT = Certified Medical Transcriptionist
- ☐ CBCS = Certified Billing & Coding Spec.
- ☐ CMAA = Certified Medical Admin. Asst.
- ☐ CBCS/CMAA = Certified Billing & Coding Spec. Certified Med. Admin. Asst.

Fee Enclosed: ($15.00)	Exam/Workshop Location:

Form of Payment: ***(please check one)***

☐ Check #: ☐ Money Order:

☐ Visa ☐ Discover ☐ Master Card ☐ American Express

Credit Card #: Exp. Date: *(mm/yy)*

Signature:

Note To Exam Participant: PLEASE ENSURE THAT YOU PRINT YOUR FULL NAME & ADDRESS CLEARLY ON ALL FORMS.THIS WILL ENSURE THAT YOUR CORRECT NAME IS RECORDED ON YOUR CERTIFICATE/CERTIFICATION CARD. The NHA accepts no responsibility for any misspelling caused because of illegible handwriting. If you wish to receive a new certificate or card with correct information you will be charged a fee of $19.00 for each certification cert/card requested.

***For Office Use Only*:**

Date Received: Initials:

Date Confirmation Letter Mailed: Initials:

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