AMERICAN CERTIFICATION AGENCY
FOR HEALTHCARE PROFESSIONALS

P.O. Box 58
Osceola, IN 46561
TEL: (574) 254-1307
FAX: (574) 254-1307

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 the eligibility requirements for certification on the next page.

3. Before submitting this application, make sure you have provided the following:

   _____ $100.00 application fee (must accompany the application); **Copy of a PICTURE ID**.
   _____ Proof of high school graduation or equivalent
   _____ If applicable, official final transcript stating graduation from phlebotomy school, college or training program
   _____ If applicable, copy of state license or other phlebotomy certification
   _____ 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, phlebotomy and ECG and a clinical experience.

   C. ☐ Successful completion of a formal patient care technician or equivalent program.

3. All applicants applying under 2 A. and 2 B **must take and pass** the ACA examination for Certified Patient Care Technician (CPCT).

Part I. **PERSONAL INFORMATION**

Full Name_____ **Social Security Number** xxx / xx /_____

Street Address_____ **City**_____ **State**_____ **Zip** _____

Home Phone Number(_____)_____ **Work Phone Number** (_____)_____

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	Hrs. completed	Degree

C. Training: Specify Type

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

Applicant Name_____ **Birthdate**_____

Facility 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 and a clinical experience. I recommend this applicant as a qualified candidate for certification as a Patient Care Technician of the American Certification Agency.

Official Signature_____ **Date**_____

Title/Position_____

PART III. EMPLOYMENT EXPERIENCE

Patient Care, ECG and Phlebotomy Experience

All patient care, ECG and phlebotomy experience credited toward certification must be earned within the last 3 years 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's Name** **Telephone number**

_____

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2. **Facility** _____ **Employment dates (mo. & yr.)**

Address:

_____ **From** _____/_____ **to**

_____/_____

Position Held **Supervisor's Name** **Telephone number**

_____

_

3. **Facility** _____ **Employment dates (mo. & yr.)**

Address:

_____ **From**_____/_____ **to**

_____/_____

Position Held **Supervisor's Name** **Telephone number**

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** **Zipcode**

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 hearby 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 the 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

_____