Application for Certification as a
CERTIFIED ECG TECHNICIAN – CET(ACA)
Print or type your name exactly as you want it to be on your certificate.

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<th>Last Name</th>
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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 6 months of work experience using ECG skills.
   b. [ ] Successful completion of a structured ECG Technician program.
   c. [ ] Have a current, valid certification obtained by an examination from another certification agency or society approved by ACA. These applicants will be considered for ACA certification without taking another exam. Recertification requirements must be met.
3. All applicants applying under 2a and 2b must take and pass the ACA examination for ECG Technician CET (ACA).

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. ECG Training

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 ECG Technician of the American Certification Agency.

Official Signature ____________________________ Date __________________

Title/Position ____________________________

Part III EMPLOYMENT EXPERIENCE

Approved ECG Experience

All approved ECG 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 _________________

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Birth Date: ________________________ Social Security Number ________________________

Granted Certificate # ________________________ Issue Date ________________________

Recert. Dates ________________________