Application for NPCTA CPCT Certification Examination New Candidate

Please Type or Print Clearly

I. PERSONAL INFORMATION

(Type or Print Name as you would want it to appear on certificate)

Name:

_____

(Last) (First) (MI) (Mr./Mrs./Ms./Miss)

_____

(Current Position/Title)

_____

(Organization)

Preferred Mailing Address: Is this your ☐ Home or ☐ Office

(Note: This is the address where score reports and other program information will be sent. You may want to use your home address for reasons of confidentiality.)

_____

(Number and street name or P. O. Box number) (Suite or Apartment)

_____

(City) (State or Province) (Postal or Zip Code)

Alternate Mailing Address: Is this your ☐ Home or ☐ Office

_____

(Number and street name or P. O. Box number) (Suite or Apartment)

_____

(City) (State or Province) (Postal or Zip Code)

Daytime Phone: ( ) _____ - _____ **Home Phone: ( ) _____ - _____**

Fax: ( ) _____ - _____ **E-Mail Address: _____**

(Admission letter sent via email)

Date of Birth: _____/_____/_____

Are you a NPCTA Member? ☐ Yes, member # _____ ☐ No, please send membership information

School or University from which you graduated: _____

Date of graduation: _____ **City/State: _____**

Highest Degree Attained: ☐ High School Diploma or GED ☐ Trade's ☐ Associated ☐ Other

_____

II. EXAMS – Indicate the exam(s) and location(s) you are applying for. The following exams are offered on a quarterly basis. Once you have submitted this form you will be contacted to set up a time and place to take the exam. Please check the box of the exams that you need to take. Please note you can only take two exams in one day.

- ❑ **Certified Patient Care Technician***

III. EXAMINATION FEES

____ **First examination**

____ **Retake examination**

_____ **$125 for the first examination in the NPCTA certification program**

Total Amount to Charge $ _____

The examination fee is payable in U.S. dollars by check, money order, MasterCard® or Visa® credit card. Please indicate method of payment below.

____ Check enclosed (***Payable to Radford University***)

____ Money order enclosed

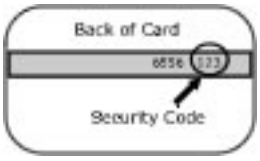
Charge to:

____ MasterCard®

____ Visa®

Card number: _____

Expiration date: _____ / ____



Security Code: _____

The examination fee and documentation of eligib*i*lity should be mailed with this application to:

NPCTA
378 Boston Post RD
Orange, CT 06477
Phone: 202-446-1400 TF: 855-601-8195 Fax: 855-460-6735
Email: NPCTAINFO@gmail.com

IV. CANCELLATION AND TRANSFER POLICY

Five (5) days or more prior to exam = $25 Processing fee per exam
No Show/fail to appear for assigned exam(s) = NO REFUND

The application, documentation and payment must be submitted at the same time. An application that is incomplete, incorrect, illegible or missing documentation will be returned.

I, the undersigned, certify that the information I have provided is correct. I have read the *Candidate's Guide* and agree to abide by regulations contained therein. I attest to my meeting eligibility requirements for participation in the NPCTA Certification Program as described in the *Candidate's Guide.*

Signature: _____ **Date:** ____/ ____ / ____

V. CHECKLIST BEFORE MAILING

NOTE: If you have already taken at least one exam in the series, you need NOT submit another transcript. Please provide current personal information in section one (I) and update employer and title/position information on page 4 (Work History Form) of this application.

____ Complete all four pages of this application.

____ Sign this application.

____ Attach an official copy of your school/university transcript indicating receipt of at least a completion from an accredited institution. ***A candidate-produced photocopy is not acceptable.***

____ Attach the completed "Work History Form (page 4)" indicating at least one years of work experience during the past 3 years.

____ Enclose a check, money order or indicate payment by credit card.

____ Mail all materials to the address indicated on page 2.

It is the candidate's responsibility to establish proof of delivery of application to NPCTA. Confirmations, via email, will be sent upon receipt of application. If you are mailing your application less than 10 days before the deadline, it is suggested that you use certified mail or other traceable form of delivery.

NPCTA CERTIFICATION EXAMINATION - WORK HISTORY FORM

Use this form to report at least ONE (1) year of primary employment during the last three years. Only full-time permanent positions should be entered. List positions in chronological order, beginning with your current or most recent position.

(Please Type or Print)

Position/Title	Employer	From (Month/Year)	To (Month/Year)
_____		___ / ___	_/_
_____		___ / ___	_/_
_____		___ / ___	_/_
_____		___ / ___	_/_
_____		___ / ___	_/_
_____		___ / ___	_/_
_____		___ / ___	_/_
_____		___ / ___	_/_

Attach this completed form to your "Application for NPCTA Certification Examination"

National Patient Care Technician Association (NPCTA)
Related Work Experience Verification Form

Directions

Thank you for taking the time to assist the applicant named below verify and document his or her related work experience in the field of Medical.

Please carefully read the Related Work Experience Form below. If you have any question as to whether or not specific duties or tasks are eligible to meet Related Work Experience Requirements, please contact our offices directly

To document the applicant's related work experience you must complete this form in its entirety and attach supporting documentation describing the duties and tasks performed by the applicant, such as a position description. In the absence of an official position description, a narrative and listing of duties written on agency letterhead may be provided.

Please do not ask the applicant to complete any part of the form, **except Part 1**. It is our policy that the applicant's employer's personnel officer, volunteer supervisor, or designee completes this form only.

Upon completion, please submit the form and supporting documentation directly to NPCTA via fax or email. The applicant can also submit this form in its entirety.

NPCTA
378 Boston Post RD Suite1000
Orange, CT 06477
Phone: 855-601-8195 Fax: 855-460-6735
Email: NPCTAINFO@gmail.com

Description of a Qualified Healthcare Professional

The participants must be qualified health care professionals based on criteria set forth by the certification agency.

Pre-requisites for Program Participation:

Our certification and continuing education programs are only designed for those persons who possess competency in the healthcare field, and have a prior background in healthcare by way of experience, schooling, and/or job training, such as:

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (safe, consistent, and successful) in performing each of the critical skill areas as identified below. (Note: Actual patient care verification in an ambulatory care, medical office, or clinic environment is required.

National Patient Care Technician Association

Related Work Experience Verification Form

Part 1: To be completed by the applicant prior to providing to the employer for completion.

Applicant Information. Please list your employment history for which you are requesting for certification and verification by your employer. Report employment dates in the following format: May 2000 – Aug 2004. Use a separate form for each position and/or employer.

Applicant Name:

Employer: _____

Type of Position (select all that apply): ❒ Full-time ❒ Part-time ❒ Paid ❒ Volunteer

Position Title: _____

Employment Dates: _____

Immediate Supervisor: _____

Part 2: To be completed by the personnel officer, volunteer supervisor or designee only.

Section A: Verifier's Information

Last Name | **First Name**

Title | **Employer**

Employer Webpage Address | **Business Phone**

Work Address Line 1

Work Address Line 2

City | **State**

Zip code | **County**

Section B: Experience Attestation

I have read and understand the on-the-job experience requirements for National Patient Care Technician Association (NPCTA) certification program. Employment records maintained by the agency can verify the following information.

Applicant's Position Description Attached? ❒ Yes ❒ No*

*If no, please attach a written description of the applicant's duties on agency letterhead.

Applicant's Dates of Employment: _____

Type of Position (select all that apply): ❒ Full-time ❒ Part-time ❒ Paid ❒ Volunteer

Average number of hours per week providing related services: _____

By my signature, I attest that the above material is true to the best of my knowledge.

Signature | **Date**

National Patient Care Technician Association

Related Work Experience Verification Form

Related job duties: Please briefly describe employee's major functions and/or attach a copy of their job description to this form. Please include duties not related to healthcare as well. Note: if paid hours per week vary over the time of employment at the same job, the certification board will request a letter of explanation.

Vital Signs/Measurements	**Initials**
ECG Performances	**Initials**
Sterile Technique	**Initials**
Venipuncture	**Initials**
Nursing Assistant skills	**Initials**
Capillary Puncture	**Initials**
ECG Performance	**Initials**
Identification of Basic Rhythm, Artifacts, Interference	**Initials**
Equipment Care, Use, maintenance	**Initials**
Holter Monitor	**Initials**
Claims Processing	**Initials**
CPT Coding	**Initials**
ICD-9-CM & HCPS Level II Coding	**Initials**
Medical Office Computers	**Initials**
Vital Signs, Exam Preparation, Office Emergencies	**Initials**
General Principles	**Initials**
Basic financial medical record management	**Initials**
Equipment and supply	**Initials**
Appointments and scheduling	**Initials**

_____

Signature Title Date