American Medical Technologists Institute for Education (AMTIE)
CONTINUING EDUCATION CREDIT REQUEST FORM

(Please print or type)

AMT MEMBERS

Name ______________________________ AMT ID# ______________

Street Address ____

City ____________________ State ______________ Zip Code __________

Certification Type: MT ___ MLT ___ RMA ___ RDA ___ RPT ___

CMAS ___ COLT ___ CLC ___ AHI ___

Job Responsibility: ____

Title of program:	Date of program:
Type: ______ Seminar/Lecture ______ Workshop	Length of program in hours: ______ (Minus lunches and/or breaks)
Name of sponsoring organization/company:	
Check proof of attendance enclosed with this form: ______ **Certificate of attendance** ______ **Other (specify)** ______________________	
THIS SECTION FOR COLLEGE PROGRAMS ONLY College/University attended: ______________________ Course Title: ______________________ Dates attended : from ______ to ______ Numbers of hours requested: ______semester OR ______quarter Check to verify that copy of final transcript is enclosed	

THIS FORM MUST BE SIGNED AND DATED BELOW:

I certify that, to the best of my knowledge, the above information is correct.
Proof of my activity is enclosed.

Signature ______________________________________ Date _________

Send this form with required validation of activity to:

AMTIE
10700 West Higgins Road
Rosemont, Illinois 60018
Phone (847) 823-5169 • www.amt1.com