



**Application for Certification as a
REGISTERED MEDICAL ASSISTANT – RMA (AMT)***



(Print or type)

Last name First name Middle initial

Permanent or mailing address

City State Zip + 4

Social Security Number

IMPORTANT NOTICE TO APPLICANT

Read requirements for certification and follow instructions printed on page 2 of this application before completing.

Qualified applicants are considered for certification without regard to race, creed, color, national origin, age, gender, disability, or place of employment.

To help us comply with Federal/State equal opportunity record keeping, reporting, and other legal requirements, please answer all questions.

Do not write in space below

Date Application Received		Date Completed		Approved by	
Application rejected by		Reason		Date Notified	
Exam Date	Test Series	Exam ID	Exam Site/Proctor	Exam Score (or DNT)	Fee Paid
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Issue Date:			GRANTED: certificate #		

***Registered Service Mark in the U.S. Patent and Trademark Office**

MEDICAL ASSISTANT

A medical assistant is an integral member of the health care delivery team, qualified by education and experience to work in the administrative office, the examining room and the physician's office laboratory. The medical assistant, also a liaison between doctor and patient, is of vital importance to the success of the medical practice.

REQUIREMENTS FOR CERTIFICATION AS A REGISTERED MEDICAL ASSISTANT – RMA (AMT)

1. Applicant shall be of good moral character.
2. Applicant shall meet one of the following requirements *(Check one box only)*:
 - A. Applicant shall be a graduate of, or scheduled to graduate from: *
 - 1) a medical assistant program that holds programmatic accreditation by (or is in a post-secondary school or college that holds institutional accreditation by) the Accrediting Bureau of Health Education Schools (ABHES) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP).
 - 2) a medical assistant program in a post-secondary school or college that has institutional accreditation by a Regional Accrediting Commission or by a national accrediting organization approved by the U.S. Department of Education, which program includes a minimum of 720 clock-hours (or equivalent) of training in Medical Assisting skills (including a clinical externship).
 - 3) a formal medical services training program of the United States Armed Forces.
 - * If you graduated within the last three years proof of work experience is not required. If you graduated over three years ago, you will be required to show proof of current work experience.
 - B. Applicant shall have been employed in the profession of Medical Assisting for a minimum of five (5) years, no more than two (2) years of which may have been as an instructor in the post secondary medical assistant program (proof of current work experience and high school education or equivalent is needed). Employment dates must be within the last five (5) years.
3. The AMT Board of Directors has further determined that applicants who have passed a generalist medical assistant certification examination offered by another medical assisting certification body (provided that exam has been approved for this purpose by the AMT Board of Directors) and who have been working in the medical assisting field for the past three out of five years and who have met all other AMT training and experience requirements, may be considered for RMA(AMT) certification without further examination.

SPECIAL INSTRUCTIONS TO APPLICANT

1. Please type or print all information **except** where signatures are required.
2. Please check the requirement above under which you are applying.
3. Before submitting this application, make sure you have provided the following:
 - \$90.00 application fee
 - Proof of high school graduation or acceptable equivalent enclosed if applying under requirement B
 - Official final transcripts stating graduation from medical assistant school, college, or training program (with school seal affixed or notarized)
 - All solid line areas completed by applicant; all dotted line areas completed by designated person
 - Relevant dotted line areas completed by designated person
 - Complete names and address of employers for experience verification
 - Application signed and dated by applicant on back page
 - Signed and dated examinee agreement
4. An applicant who does not appear at his/her scheduled examination will be assessed a \$60.00 fee for subsequent rescheduling.
5. Applicant must present photo identification at time of testing.

PART I. PERSONAL INFORMATION

Full Name _____ E-mail _____	
Street Address _____ City _____ State _____ Zip + 4 _____	
Daytime Phone Number () _____ Date of Birth _____	
Maiden and/or any former names _____	
Name and address of nearest relative (do not list spouse) _____	

Have you ever been convicted of a felony? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please include the following information with your application on a separate piece of paper: when was the felony, what was the felony, what court and the outcome and please be specific. Include copies of court documents if available. NOTE: This question must be answered for your application to be processed.	
OPTIONAL INFORMATION	
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	Sex: Female <input type="checkbox"/> Male <input type="checkbox"/>
Race/Ethnic Group: White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/>	

PART II. MEDICAL ASSISTANT EMPLOYMENT

Employer Name	Street Address	City/State/Zip	Dates of Employment (month and year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate if any of the above employment was as a medical assisting instructor.

PART III. EDUCATION AND TRAINING

A. SECONDARY

SENIOR
HIGH SCHOOL

Name/Address	Dates Attended	Graduation Date
G.E.D.:	Date of Certificate/City/State	

(If applying under requirement B on page 2, proof of high school graduation or equivalent must be provided.)

B. COLLEGE OR UNIVERSITY

Name/Complete Address	Dates	Hours	
Degree	Attended	Completed	Awarded
_____	_____	_____	_____
_____	_____	_____	_____

PART III. EDUCATION AND TRAINING (continued)

C. MEDICAL ASSISTANT TRAINING

This section must be completed by a proper school or training program official to verify training in medical assisting and graduation from a course wherein the curriculum is acceptable to this organization. The applicant's final transcript must also be provided.

Applicant Name

School/Program Name

School/Program Address

Course Dates: From/...../..... To/...../.....

I hereby certify that the applicant named above did (or will) satisfactorily complete the entire prescribed medical assisting course and is recommended as a qualified candidate for certification as a Registered Medical Assistant of American Medical Technologists.

Date School Official's Signature

Title/Position

PART IV. RECOMMENDATION FOR CERTIFICATION

If you are applying under B, and have graduated over three years ago, or if your school does not meet the requirements as stated, this section must be completed for the application to be processed.

Physician Signature

AMT Member Address

(If member) AMT Registry #

PART V. OPTIONAL SCORE RELEASE

Some educational institutions request their graduates' examination results. Signing this release is VOLUNTARY, and will not affect the outcome of your examination in any way. If you do NOT want your results released, DO NOT sign the authorization.

I hereby authorize American Medical Technologists to release my examination results to the school listed in III C above.

Signature of Examinee

PART VI. AGREEMENT

I consent to give AMT the authority to request the necessary information from individuals, institutions, and/or organizations named herein in order to validate credentials for certification.

I certify that the statements made herein are 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 MEDICAL TECHNOLOGISTS.

ENCLOSED HERewith IS MY APPLICATION FEE OF NINETY DOLLARS (\$90.00). *

Date _____ Signature _____

***NOT REFUNDABLE. Applicant may take the examination two times on this application. A retake is permitted no sooner than three (3) months from the first attempt and no later than two (2) years after the date of the application. A retesting fee of \$60.00 will be required for a second administration. If the applicant fails to show for a scheduled examination, a fee of \$60.00 will be required before he/she may sit for the rescheduled examination. If the applicant fails the second administration, he/she must file a new application with a new fee of \$90.00, and proof of further education/training to be tested a third time. The applicant may also take the examination two times on the second application but must adhere to the time frames and fees as stated above. If the applicant fails to honor any application within two (2) years of submitting, a new application with appropriate fees must be filed.**

Note: Please be aware that AMT's certification application forms are amended from time to time with changes impacting those eligibility requirements set forth in the application. Therefore, if you are submitting an application form that was printed several months or years ago, it may not disclose current criteria and conditions added subsequent to the printing of that form. All applicants are held to compliance with current eligibility requirements (including payment of current fee amounts) that are in place at the time of submission of their application, notwithstanding differences from the older, printed application being submitted. All current AMT certification applications are available for viewing and printing at AMT's website, www.amt1.com.

Visa MasterCard Discover Card Credit card number: _____ Expiration: _____

Name on Card: _____ Signature: _____

**If you are paying by check or money order, make payable to:
AMERICAN MEDICAL TECHNOLOGISTS
10700 W. Higgins Road Suite 150 • Rosemont, Illinois 60018 • Phone (847) 823-5169 • Website www.amt1.com**

By sending your completed, signed check to AMT, you authorize AMT to use the account information from your check to make a one-time electronic fund transfer from your account for the same amount as the check. If the electronic fund transfer cannot be processed for technical reasons, you authorize us to process the copy of your check. Please contact the account receivable department at jackie.leibach@amt1.com for other payment options.