

MEDICAL ADMINISTRATIVE SPECIALIST

The Certified Medical Administrative Specialist serves a key role in medical office, clinic, and hospital settings. This multi-skilled practitioner is competent in medical records management, insurance processing, coding and billing, management of practice finances, information processing, and fundamental office management tasks. This practitioner also maintains familiarity with clinical and technical concepts required to coordinate administrative office functions in the healthcare setting.

REQUIREMENTS FOR CERTIFICATION AS A MEDICAL ADMINISTRATIVE SPECIALIST – CMAS (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 office administrative 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).
 - 2) a medical office administrative 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 office administrative skills (including a practical externship). Training program must have been structured to include at least the following content areas: 1) medical records management, 2) health care insurance processing, coding and billing, 3) office financial responsibilities, and 4) information processing.
 - B. Applicant shall be certified as a Registered Medical Assistant (RMA) (or equivalent) and possess a minimum of two (2) years experience working as a medical office administrative specialist.
 - C. Applicant shall have been employed as a medical office administrative specialist for a minimum of five (5) years.

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 C
 - Official final transcripts stating graduation from medical office administrative 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 date 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 _____ E-mail _____	
Name and address of nearest relative (do not list spouse) _____ _____	
<p>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 <u>on a separate piece of paper</u>: 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.</p>	
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 ADMINISTRATIVE SPECIALIST EMPLOYMENT

Employer Name	Street Address	City/State/Zip	Dates of Employment (month and year)
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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 C on page 2, proof of high school graduation or equivalent must be provided.)

B. COLLEGE OR UNIVERSITY

Name/Complete Address	Dates Attended	Hours Completed	Degree Awarded
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PART III. EDUCATION AND TRAINING (continued)

C. MEDICAL ADMINISTRATIVE SPECIALIST TRAINING

This section must be completed by a proper school or training program official to verify training in medical office administrative 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 office administrative course and is recommended as a qualified candidate for certification as a Medical Office Administrative Specialist of American Medical Technologists.

Date School Official's Signature

Title/Position

PART IV. RECOMMENDATION FOR CERTIFICATION

If you are applying under requirement C or 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. 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 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.

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.