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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<th>Exam Date</th>
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Birth Date: ___________________________ Social Security Number ______________________________

Granted Certificate # ______________________ Issue Date ______________________________

Recert. Dates ________________________________