EXAMINATION RETAKE FORM – CALIFORNIA / WASHINGTON

This form should ONLY be used by active certified AMT members retaking the exam for state licensure.

- MT exam for state of California
- RMA exam for state of Washington

1. Applicants are limited to a life-time of four (4) examination attempts for any one AMT certification (including all previous attempts).
2. A retake is permitted NO SOONER THAN forty-five (45) days from date of the previous attempt.
3. A non-refundable / non-transferable processing fee (see below) is required for each attempt of the certification examination (see chart below).
4. A candidate who fails a FOURTH (4th) attempt is not eligible to take that certification examination an additional time.

NAME: _____________________________________________ APPLICANT ID: __________
ADDRESS: ____________________________________________________________________________
CITY/STATE/ZIP: _______________________________________________________________________
PHONE: ___________________________ CELL: ___________________________

I wish to retake the following certification examination for the purpose of State certification:

☐ RMA ($90.00)  ☐ MT ($110.00) – Please provide your LFS # - ________________________________

Informed Consent of Score Use
☐ I understand that information concerning my performance on this AMT examination may be shared with state licensing boards and other state regulatory oversight agencies.

Enclosed is my payment: ☐ Check ☐ Money Order (Payable to: American Medical Technologists)
☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Credit Card Number: ______________________________________________________________________
Expiration Date: ______________ ______________________ CVV: ________________________________
Name on Card: __________________________________________________________________________
Credit Card Billing Address: __________________________________________________________________
City/ State / Zip: __________________________________________________________________________

Signature: ___________________________________________ Date: ____________________