



National Healthcareer Association

**NO Application Fee**  
Schedule Your Own Exam Dates  
Use Your Staff as Proctors

*"The Benchmark In Allied Healthcare Certification"*

## Application for School/Organization Site Approval

Please complete the entire application. **No application fee required.**

Allow only 1 to 2 weeks for the NHA Advisory Board to approve and/or make suggestions.

School/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

School Email (required): \_\_\_\_\_ School Website: \_\_\_\_\_

How long has the school been in operation? \_\_\_\_\_

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: \_\_\_\_\_

Your Email (required): \_\_\_\_\_

### How did you hear about NHA? (please check one)

- Internet(search engine/web site) \_\_\_\_\_
- Literature From NHA \_\_\_\_\_
- Recommended by \_\_\_\_\_
- Publication (which one) \_\_\_\_\_
- Trade show \_\_\_\_\_
- Call From NHA \_\_\_\_\_
- NHA/ATI Rep \_\_\_\_\_

How would your school/organization like to test: (please check)

- Online - **(No software needed)**
- Paper and Pencil

I would like to learn more about being a Subject Matter Expert for the NHA Professional Education Board.

- Yes  No Area of Expertise \_\_\_\_\_

### Who is the person(s) responsible for the Allied Healthcare training program?

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Email: \_\_\_\_\_

### Who would be the person(s) responsible for scheduling exams?

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Email: \_\_\_\_\_

### Any other faculty/instructors NHA should keep in your school file?

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Email: \_\_\_\_\_

(continued, please complete other side →)

**Check any of the following programs/courses that are provided by your school/organization.**

|   | Length of Program<br>(# of hours) | Avg. # of<br>students/class | # of times program<br>taught per year |
|---|-----------------------------------|-----------------------------|---------------------------------------|
| <input type="checkbox"/> <b>Clinical</b>  |                                   |                             |                                       |
| <input type="checkbox"/> Certified Phlebotomy Technician (CPT)  | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified EKG Technician (CET)   | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified EKG/Certified Phlebotomy Technician (CET/CPT)                                    | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified Clinical Medical Assistant (CCMA)*   | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified Medical Laboratory Assistant (CMLA)  | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified Operating Room/Surgical Technician (CORST)                                       | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified Patient Care Technician/Patient Care Associate/Nurse Technician (CPCT/PCPA/CNT)* | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified Mental Health Technician (CMHT)  | _____                             | _____                       | _____                                 |
| <input type="checkbox"/> Certified Pharmacy Technician (CPhT)   | _____                             | _____                       | _____                                 |

**Administrative**

|   |       |       |       |
|---|-------|-------|-------|
| <input type="checkbox"/> Certified Electronic Health Record Specialist(CEHRS)   | _____ | _____ | _____ |
| <input type="checkbox"/> Certified Billing & Coding Specialist (CBCS)   | _____ | _____ | _____ |
| <input type="checkbox"/> Certified Medical Transcriptionist (CMT)   | _____ | _____ | _____ |
| <input type="checkbox"/> Certified Medical Administrative Assistant (CMAA)  | _____ | _____ | _____ |
| <input type="checkbox"/> Certified Billing & Coding Specialist/<br>Certified Medical Administrative Assistant (CBCS/CMAA) | _____ | _____ | _____ |

**Instructor**

|  |       |       |       |
|--|-------|-------|-------|
| <input type="checkbox"/> Certified Healthcare Instructor (CHI) | _____ | _____ | _____ |
|--|-------|-------|-------|

\*Exam includes Phlebotomy and EKG

**Other** \_\_\_\_\_

**If your school/organization is not running any of the above programs please contact NHA for curriculum development at NO Cost.**

**Exam Fee Options:** please select one

- |   |  |
|---|--|
| <input type="checkbox"/> Built into school tuition                  | <input type="checkbox"/> Preregistration on NHA online Application |
| <input type="checkbox"/> Prepaid Voucher (bulk discounts available) | (mail in with payment option)                                      |
| <input type="checkbox"/> Invoice/Purchase Order                     | <input type="checkbox"/> Students Preregistration                  |

**Please give approximate exam schedule with estimate number of students, dates and time. In order to successfully add your dates to the NHA exam calendar all fields must be complete.**

| Estimate #<br>Students | Date of Exam<br>Month/Day/Year | Time  | Testing For |
|------------------------|--------------------------------|-------|-------------|
|                        | / /                            | AM PM |             |
|                        | / /                            | AM PM |             |
|                        | / /                            | AM PM |             |
|                        | / /                            | AM PM |             |
|                        | / /                            | AM PM |             |
|                        | / /                            | AM PM |             |

**Enclosed for the Advisory Board to review:**

- |  |   |
|--|---|
| <input type="checkbox"/> NHA application completed in full       | <input type="checkbox"/> Copy of State/<br>Board of Education approval(s) |
| <input type="checkbox"/> Curriculum for program seeking approval |   |

**Upon approval your organization/school will receive:**

- A Certificate of Approval ■ Letter of Approval ■ Confirmation of Exam Schedule ■ NHA Literature
- Posters (with Exam Schedule) ■ Registration Forms ■ Bi Monthly eNews (email required)

\_\_\_\_\_  
School Official, Print Name and Title

\_\_\_\_\_  
School Official Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
NHA/ATI Sales Representative

\_\_\_\_\_  
Date

The NHA reserve the right to suspend or revolt any approved testing site, based on the compromise of NHA exams, regulations, standard or practices.

**Mail this Application to: National Healthcareer Association - Headquarters**

7 Ridgedale Ave, Suite 203, Cedar Knolls, NJ 07927

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Rev0809