Proof of Eligibility Form

Member Name: ____________________________

Certification Number: ______________________

Directions: (1) Select which form of documentation you wish to submit as proof of eligibility to sit for the American Allied Health certification exam, (2) comply with the directions given in either option a, b, or c, and (3) mail or fax in this form to American Allied Health.

Check ONE of the boxes below:

[ ] (a) Proof of graduation from vocational training program, or military training.
[ ] (b) Proof of one year of work experience in the field.
[ ] (c) Apply for certification by reciprocity.

Option (a): Mail or fax this form along with a copy of your proof of training (e.g., certificate of training, diploma) to the contact information at the bottom of this page.

Option (b): Have your employer or supervisor fill out the following information:

“I (supervisor’s name) __________________________ certify that (AAH member’s name) __________________________ has been employed as an allied health professional with at least one year of work experience in the field.”

Supervisor’s Name: __________________________
Supervisor’s Signature: ________________________
Supervisor’s Phone: ____________________________

Option (c): If you have previously been certified with another certification organization within the last five years, submit the following information:

Previous Certification Organization: __________________________
Certification Number: __________________________
Certification Expiration: __________________________