EXAMINATION RETAKE FORM – CALIFORNIA / WASHINGTON

This form should ONLY be used by active certified AMT members retaking the RMA exam for state of Washington OR MT exam for state of California exam for state licensure.

This authorization is valid for one year from date of submission.

1. Applicants are limited to a lifetime 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)
RMA ONLY: I will be testing: □ At a Pearson VUE testing center   □ Online using a personal computer
CA State Licensure □ 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: ____________________

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