AMT
American Medical Technologists
Certifying Excellence in Allied Health

PATIENT CARE TECHNICIAN (PCT)
SUPPLEMENTARY TRAINING EVALUATOR FORM

AMT has received an application for certification from the applicant listed below. Your cooperation in evaluating this candidate for certification with American Medical Technologists will be appreciated.

From: ❑ **Instructor** ❑ **Supervisor** ❑ **Evaluator**

Name _____ Organization _____

Mailing Address _____ Business E-mail _____

City _____ State/Province/Country _____ Zip _____

Applicant Name (please print) _____ **AMT ID # (if known)** _____

Date of Training: **(Exact dates please)** From (mm/dd/yy) _____ To (mm/dd/yy or current) _____

Was the applicant trained in patient care duties and knowledge, as defined by the representative areas presented in the box below. ❑ Yes ❑ No

Check all boxes indicating the area(s) in which the applicant received training:

❑ Phlebotomy and Specimen Collection
❑ Wound Care
❑ First Aid
❑ Law and Ethics of Patient Care
(e.g., HIPAA, consents, and scope of practice)

❑ Vital Signs and Measurements
❑ EKG
❑ Patient Personal and Environmental Safety
❑ Personal Patient Assistance and Care (to include activities of daily living)
(e.g., Bathing, Positioning and Turning, Transport, Nutrition, and Bed making)

Optional Comments: _____

I am a current/previous instructor, evaluator, supervisor, or designated Human Resources representative. I attest that the information above is accurate and is a fair representation of the duties performed by the applicant.

Name (Print): _____ Title: _____

Signature: _____ Date: _____

Email completed documents to documents@americanmedtech.org for review. Documents will only be reviewed if an active application is on file.