

## **CERTIFICATION VERIFICATION SERVICES REQUEST FORM**

- 1. To request a state verification or visa screening, complete and return this form with your payment.
- 2. The service fees below are non-refundable.
- 3. Forms submitted with a credit card payment can be emailed to documents@americanmedtech.org

Full Name:		AMT ID#:	
Address:			
City:	State:	Zip/Postal Code:	SSN#
Phone Number:	En	nail:	
*Must be a d	currently active member of	AMT to take advantage of di	scounted member fees.
Verification of Certification	n Letter to State		
Do NOT submit this forn	n until you have submitted you	ır application for state licensure t	o the state in which you are applying.
Fee Per Letter:	□ \$45.00 / \$65.00 (Member/Non-Member *)	State(s) for which c	ertification is requested:
Number of Letters	:		
Validation of Registration  Must be submitted alor  Fee Per Letter:		ening form, which can be obtaine	d by emailing support@CGFNS.org. tions for inactive members
Priority Mailing (O)	otional Additional Fee) :	<b>1</b> \$15.00 (2-3 Days) □ \$3	0.00 (1-2 Days)
Enclosed is my payment:			Total Fees Enclosed
☐ Visa ☐ Mast	terCard 🗖 Discover	☐ AMEX ☐ Check/Mor	ney Order (Payable to AMT)
Credit Card Number:		CVV #	Expiration Date:
Name on Card:			
Billing address:			Zip Code:
Signature:			Date:

By sending your completed, signed check to AMT, you authorize AMT to use the account information from your check to make a one-time electronic fund transfer from your account for the same amount as the check. If the electronic fund transfer cannot be processed for technical reasons, you authorize us to process the copy of your check.