



NAHP Supervised Professional Experience Form

The NAHP applicant is to fill out his/her name as well as the demographic information of the supervisor or employer. The Supervised Professional Experience Form is then provided to the supervisor or employer for completion. The supervisor or employer is to fill out the Form in its entirety.

NAHP Applicant Name: _____

Applicant Social Security Number: _____

Job Title of Applicant: _____

NAHP Examination Seeking Eligibility:

- | | |
|---|---|
| <input type="checkbox"/> Nationally Registered Certified Medial Assistant (NRCMA) | <input type="checkbox"/> Nationally Registered Certified Coding Specialist (NRCCS) |
| <input type="checkbox"/> Nationally Registered Certified EKG Technician (NRCEKG) | <input type="checkbox"/> Nationally Registered Certified Administrative Health Assistant (NRCAHA) |
| <input type="checkbox"/> Nationally Registered Certified Phlebotomy Technician (NRCPT) | <input type="checkbox"/> Nationally Registered Certified Pharmacy Technician (NRCPhT) |
| <input type="checkbox"/> Nationally Registered Certified Patient Care Technician (NRCPCT) | <input type="checkbox"/> Nationally Registered Certified Surgical Technician (NRCST) |
| <input type="checkbox"/> Nationally Registered Dental Assistant (NRDA) | |

Supervisor / Employer Instructions: Please carefully answer ALL questions and use another sheet of paper, if necessary.

Once completed, the applicant is required to submit this form with their NAHP certification application. The information contained in this form is considered confidential.

Name of Person Filling Out Form: _____

Job Title: _____

Institution/Practice/Facility Name: _____

Address: _____

City/Province: _____

State: _____

Zip Code: _____

Contact Number: _____

Email: _____

1. What is your present and/or past association with the applicant? *(Check all that apply)*

- Referring Physician / Clinician Supervisor
 Training Mentor/Educator Employer
 Other: _____

2. Please provide dates for applicant's employment:

Start date: _____ End date: _____ If currently employed, place CURRENT on end date line.

3. List or attach job duties performed: _____

If Laboratory is included, can the number of Phlebotomy sticks performed be verified? Yes No

If yes please document here: Number of Venipunctures: _____ Capillaries: _____

4. How would you rate the applicant's overall competency in the professional, and credential- relevant, healthcare field?

- Excellent Good Fair Poor

5. Is there any additional knowledge that is relevant to the applicant's eligibility for the NAHP examination or ability to provide safe and effective care as a healthcare professional?

- Yes No

If Yes, please elaborate:

I attest that the information and personal accounts contained herein concerning the named NAHP applicant are true and accurate.

Printed Name: _____

Signature: _____

Date: _____

