

MedCA Certifications



Qualification by Experience Form

To be completed by the applicant

Date _____

Name _____

Address _____

Phone _____ Email Address _____

Work Experience (i.e. duties, responsibilities, job description, etc.)

What certification are you applying for based upon your work experience? _____

I _____, allow the information on this application to be forwarded to MedCA Certifications.

Signature of Applicant _____

To be completed by the applicant's direct supervisor

The person named above is applying for certification based upon work experience. As such, the applicant must have documentation reflecting full-time work experience in the certification for which they are applying. An employer can only verify work experience performed at their own facility. Please note that actual work in an ambulatory care, medical office or clinical environment is required.

Date: _____

Applicant's employment dates from _____ / _____ (month/year) through _____ / _____

Supervisor Contact Information:

Organization Name _____

Address _____

Phone Number _____

Title _____

Signature _____

Print Name _____