



AMERICAN EDUCATION CERTIFICATION ASSOCIATION

Phone : 815-315-8721
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Email : info@aecacert.com
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Approved Testing Site Application

Academic Institution Information

Institution Name: _____
Website: _____
Address: _____
City : _____ State: _____ Zipcode: _____
Phone: _____ Fax : _____
Email: _____

Certification Exam Scheduling & Billing Contact Person

Main Contact Name: _____
Title: _____
Main Contact Email: _____
Main Contact Phone : _____ ext: _____ Phone 2: _____ ext: _____
Directors Name: _____

Certification Exams (Select {} Approved Programs)

Allied Medical Healthcare Certifications

_____ Medical Assistant
_____ Clinical Medical Assistant Specialist
_____ Patient Care Technician/Assistant
_____ Phlebotomy Technician
_____ EKG Technician & Others

Rehabilitation Healthcare Certifications

_____ Rehabilitation Therapy Technician
_____ Restorative Care Assistant
_____ Clinical Massage Therapy
_____ Strength/Conditioning Rehab Specialist

Administrative Certifications

_____ Medical Billing and Coding Professional
_____ Medical Administrative Office Assistant/Office Specialist
_____ Medical Software/Insurance/Pre-authorization Specialist
_____ Electronic Health Records Professional
_____ Coding Professional [Physician & Hospital]

Fitness and Sports Certifications

_____ Personal Training Specialist
_____ Sports/Fitness Nutrition Specialist

Technology Certifications

_____ Computer Skills Specialist (Word /Excel/Power Point)

Other Certification

Type: _____

Payment Methods

Select the Payment Type

_____ School: PAYMENT OPTIONS (school pays directly on behalf of the students)

_____ CARD

_____ ACCOUNT

_____ Student: PAYMENT OPTIONS (students will pay for their exams)

_____ CARD

_____ ONLINE

By signing this document, you agree to verify all certificates of completion with regard to the education of the students testing. You also agree that you as the director are verifying the credentials of each student and attesting that they do meet the minimum standards for the AECA exam. No student should be allowed to test if their credentials/education completion is incomplete.

Directors First Name: _____ Directors Signature: _____

Directors Last Name: _____ Date: ____/____/____