



ISO 9001:2015 Certified

6020 Medical Gas Inspector Recertification Examination Request Form

(This request form is for the **2018** inspector written re-certification).

- * The fee for the exam is \$49.00 dollars. This must be prepaid. Please make check or money order payable to NITC. Visa, Master Card or American Express is also accepted. The method of payment must be attached at the time of submission. Or contact NITC to provide credit card payment information by phone at (877) 457-6482. **Note:** *In some cases payment is provided by the training agency or employer.* For NITC No-Show, Cancellation and Refund Policy refer to the Candidate Bulletin.
- * **This request should be submitted no later than three (3) weeks before examination date.** Please e-mail to medgascerts@nationalitc.com.
- * A minimum of 10 applicants is required for an examination; **if there are less than 10 applicants a processing fee of \$250.00 (paper pencil) or \$150.00 (computer based) will be applied.**
- * It is the requesting entity's responsibility to notify each applicant.

Please fill in the information below:

*Examination Location: _____

*Examination Address: _____

*City, State, Zip: _____

*Contact Person: _____ Phone No: _____

*E-mail Results to: _____

*Date of Examination: _____ Time: _____ *Number of Examinees: _____

** I _____ (name of instructor) attest that all applicants will have completed the mandatory 4-hour training course per the ASSE Series 6000 Standard 6010 prior to the test date. Signature of Instructor: _____

How would you like the exam to be provided? Computer Based Paper & Pencil

* Will any additional examinations be given along with this examination? Yes No

* Need NITC to find a proctor: Yes No

Method of Payment

(Required Fields for credit card payments**)**

*Total Amount Enclosed: \$ _____ Check Money Order Visa Master Card AMEX

*Credit Card No: _____ *Expiration Date: _____

* CVV2: _____ Last three or four digits on back of Visa and Master Card, Amex CVV2 on front of card.

*Credit Card "Billing Address": _____ *Credit Card "Billing Address" Zip Code: _____

*Name on Card: _____ *Signature: _____

As it appears on card (Please Print)

Signature as shown on credit card

Test packets will not be mailed to P.O. Boxes

Proctor's Name:			
Address:			
City, State, Zip:			
Cell Phone No:		Email:	
Will the proctor waive his/her proctoring fees?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>

Please **print or type** all the information (completely) for each applicant as you would like it to appear on their certification.

Required Fields

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	

*Name:		*S.S. # / UA #/ Cert ID #:	
*Address:		*City:	
*State:		*Zip:	
Phone #:		E-mail:	