

AAPT

Application to take the examination for

Nationally Certified Psychiatric Technician

Mail this application with your check or money order made out to: **AAPT**

Mail to: AAPT, 1220 S Street, Suite 100, Sacramento, CA 95811-7138

First Name Middle Initial Last Name

(Choose one) Mr Mrs Ms Miss Rank (if military)

Birthdate Job Title
(i.e. 02 26 1985)

Home Address

City State Zip

E-mail Address (if any)

Facility or Hospital Name

Unit, Ward, Building, Division, etc.

Facility Address

City State Zip

Home Phone Work Phone

Choose the certification level(s) for which you are applying 1 2 3 4

By signing below, you agree to the following:

1. I will not copy the test or let anyone else copy it. I will return the test in 30 days.
(For your protection, use “certified mail, return receipt requested.”)
2. I will pay a late fee of \$20 for each month or fraction thereof that the test is returned after 30 days, regardless of whether the test is completed or not.
3. If I do not return the test within 180 days, I understand it is considered lost and I must pay a fee of \$1,000 for AAPT to revise and reprint all tests.

Signature

(Submitting this form on-line constitutes your electronic signature)

Date

(mm/dd/yyyy)



If you desire a copy of this information
please save or print before submission.