CLINICAL EXAM REGISTRATION FORM

If you are a current member of ASPMA you are eligible to take the Clinical Certification Exam.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ Email: _____

Cell Phone: _____ Requested Exam Site: _____

Exam Registration Fee - $140.00 **(If received at least 30 days prior to exam date**)
Late Exam Registration Fee – $165.00 **(If received within 30 days of exam date)**

Mail with a check made payable to ASPMA Qualifying and Examining to:

ASPMA
1616 North 78th Court
Elmwood Park, IL 60707
Phone: 888-882-7762
A $25.00 fee will be charged for all returned checks.

OR

Fax with credit card information and signature to 708-456-4947
Please Print Legibly

Circle One: VISA MasterCard Discover American Express

Name as it appears on card: _____

Card Number: _____ Expiration Date: _____/_____ CVV Code: _____

Billing Address **(if different than above)**:_____

Email (For Receipt):_____

Signature: _____

Upon receipt of your Exam Registration Form, fee, and proof of membership you will be sent a confirmation of registration. Please present this confirmation to the Exam Proctor on the day of the exam.