CLINICAL EXAM REGISTRATION FORM/STUDY GUIDE

If you are a current member of ASPMA for 90 days 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 - $325.00 (If received at least 30 days prior to exam date)
Exam Registration Fee – $375.00 (If received within 30 days of exam date)

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

ASPMA
109 First Street
Itasca, IL 60143-2114
Phone: 888-882-7762

A $25.00 fee will be charged for all returned checks.

OR

Fax with credit card information and signature to 847-773-9976

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.