

CLINICAL EXAM REGISTRATION FORM/STUDY GUIDE

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 - \$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 1<sup>st</sup> 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.