



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 _____

(Circle one) Mr Mrs Ms Ms Miss Rank (if military) _____

Birthdate: ____ ____ ____ Job Title _____
month day year

Home Address _____ Apt _____

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 () _____

Circle 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

Date