Instructor ECG Technician Certification
Critical Skill Competency/Qualification by Experience Documentation

2025 - *TEI-0211CSQE*

To be completed by the applicant: (Please return this form to NCCT with your application.)

Name of Applicant _____

Today's Date (mm/dd/yyyy) _____ NCCT User ID # _____

The remainder of this form is to be completed by the applicant's direct patient care supervisor which may include, but not limited to, a licensed physician or primary care provider.

The person named above is applying for certification in the field of ECG Technician. The applicant must have documentation reflecting a minimum of one (1) year full-time work experience, including performance in each of the critical skills for ECG Technicians. In order to determine the eligibility of the applicant, we require verifiable documentation of knowledge, education, training, and proficiency in the critical skill areas as identified below. Please complete the documentation below. Only one (1) direct patient care supervisor per page.

Note: This page may be photocopied if more than one employer or direct patient supervisor will be verifying cases and providing documentation.

Critical Skill Performance Competency	*Supervisor's Initials*
Equipment Care, Use, Maintenance	
Identification of Basic Rhythms, Artifacts, Interference	
Holter Monitor	
ECG Performance *(performance of a minimum 25 ECG's)*	
Additional comments *(optional):*	

If this applicant was employed by your organization in a full-time capacity and that employment includes successful performance in these critical skills, please provide the dates of full-time employment (defined by NCCT as 40 hours per week). Each employer may only verify work experience performed at their own facility.

The applicant successfully performed the skills attested to through: ____ employment experience

from _____ / _____ through _____ / _____ or ____ present.
month *year* *month* *year*

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (safe, consistent, and successful) in performing ECG skills as identified above. (Note: Actual patient care verification is required – ***simulated clinical experiences do not meet qualification criteria).*** Please verify competency by providing your initials next to the critical skill in which you are attesting, within the ECG Technician scope of practice/employment, according to individual state laws. Your signature and legible contact information are required for valid completion of this form.

Today's Date: (mm/dd/yyyy) _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Title _____

Supervisor/Verifier Printed Name _____

Supervisor/Verifier Signature _____

Company Name _____

Business Address _____

City, State _____ Zip _____

Business Phone _____ Business Email _____

Note: The supervisor that signs this document must be able to be contacted.