National Center for Competency Testing

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Office Hours: M-F 7:30am - 7:00pm CST
Saturday 9:00am - 3:00pm CST

ECG Technician Certification Qualification by Experience

(Official Documentation of Route 2)

Rev: September 2016

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

Name of applicant _____

Today's Date (MM/DD/YYYY) _____

To be completed by the applicant's direct patient care supervisor: (Licensed Physician or Primary Care Provider).

The person named above is applying for certification in their role as an ECG Technician. In lieu of successful completion of an eligible ECG Technician program, the applicant is qualifying through work experience (NCCT Route 2 - Qualification by Experience). As such, the applicant must have documentation reflecting a minimum of one (1) year full-time work experience, within the past five (5) years, including performance in each of the critical skills for ECG Technicians. Each employer may only verify work experience performed at their own facility.

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 below. (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 that you are attesting to, within the ECG Technician scope of practice/employment, according to individual state laws. Your signature and legible information are required for valid completion of this form.

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):*	

The applicant's employment dates from _____ / _____ through _____ / _____ .
month *year* *month* *year*

Today's Date: MM/DD/YYYY _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Signature _____

Supervisor/Verifier Printed Name _____

Company Name _____

Supervisor's Title _____

Address _____ City, State, Zip _____

Phone _____ Email _____