National Center for Competency Testing
7007 College Blvd., Ste. 385, Overland Park, KS 66211
Phone 800.875.4404; Fax 913.498.1243
***Office Hours:*** M-F 7:30am - 7:00pm CST
Saturday 9:00am - 3:00pm CST



# *Medical Office Assistant 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 supervisor:*** (Licensed Physician or Primary Care Provider).

The person named above is applying for certification in their role as a Medical Office Assistant. In lieu of successful completion of an eligible Medical Office Assistant 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 Medical Office Assistants. 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 (dependable, consistent, and successful) in performing each of the skill areas as identified below. Please verify competency by providing your initials next to each skill that you are attesting to, within the Medical Office Assistant 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*** |
|---|---|
| Medical Office Computer | |
| General Principles and Practices of Insurance Billing and Cycle | |
| Medical Record Management/Electronic Medical Records – *(systems and organization)* | |
| Appointments and Scheduling | |
| Basic Financial Management | |
| Health History, Charting, Documentation Systems | |
| 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 _____