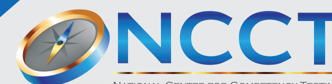
Medical Office Assistant Qualification by Experience Documentation



Phone 800.875.4404
Fax 913.498.1243
www.ncctinc.com

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 Medical Office Assistant. In lieu of successful completion of an eligible Medical Office Assistant program, the applicant is qualifying through work 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. 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. Each employer may only verify work experience performed at their own facility.

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***
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)*:	

If this applicant was employed by your organization in a full time capacity in the last 5 years and that employment includes successful performance in the 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 ____ educational training.

from __________ (month) / __________ (year) through __________ (month) / __________ (year) or _____ Present.

Note: If selecting educational training and your school's program does not have an approved NCCT Program Eligibility Application, your Critical Skill Performance Competency must be earned through employment or volunteering in a clinical setting and signed by your supervisor.

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.

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 ____________________

Note: School may not verify skills or employment. Employment and skills are to be verified in a clinical setting by employer.

TE-0207CSQE