

# REQUEST FOR DUPLICATE SCORE REPORT/CERTIFICATE

## CNA CERTIFICATE

## CNA SCORES

## AMAP CERTIFICATE

Please complete the following form with your current name and address. All information must be complete and accurate to ensure proper processing.

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ SS Number \_\_\_\_\_

**SOCIAL SECURITY NUMBER DISCLOSURE:** Disclosure of your social security number should only be made if obtained from you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary for the purpose of internal identification, and may be used to verify information on your application, (class admissions and completions, competency evaluation testing, re-registration and reciprocity applications, etc), to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.  
In accordance to the 42CFR 483.156(c), failure to provide requested information may result in your application being returned, or a delay in processing.

If the above information was different at the time you were tested, please indicate original information.

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize PHD to send me at the address above a duplicate of my score report.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Payment Options    Certified Check    Facility check    Money Order    VISA    MC    Discover

Credit Card # \_\_\_\_\_ Expiration Date (M/D/YYYY) \_\_\_\_\_ CVV2 \_\_\_\_\_

Print/Type name as it appears on credit card \_\_\_\_\_

Amount to Charge Card \_\_\_\_\_ Phone number (xxx-xxx-xxxx) \_\_\_\_\_

Authorized Card Holder Signature \_\_\_\_\_ Date \_\_\_\_\_

Mail application and \$20.00 fee to:

Professional Healthcare Development, LLC  
P.O. Box 399  
Ona, WV 25545