

REQUEST FOR DUPLICATE SCORE REPORT/CERTIFICATE

NA SCORES

EDUCATE THE EDUCATOR CERTIFICATE

Name (at time of testing) _____

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.

NATCEP Test Results

Facility Name _____ Date Testing Occurred _____

Street _____

City _____ State _____ Zip _____

I hereby authorize PHD to send test results/certificate:

Your signature _____ Date _____

SEND TO:

Contact Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Payment Options Personal Checks & Cash Not Accepted

Certified Check Facility check Money Order VISA MC Discover AMX

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

Print/Type name as it appears on credit card _____

Street Address _____ City _____ State _____ Zip Code _____

Amount to Charge Card _____ Phone number (XXX-XXX-XXXX) _____

Authorized Card Holder Signature _____ Date _____

Mail or fax request and \$20.00 fee to:

Professional Healthcare Development, LLC
P.O. Box 399
Ona, WV 25545 Fax 304-733-6146

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