

Certified Practice Manager Reciprocity Recognition Application

I hereby petition the POMAA credentials committee to provide reciprocity recognition of my medical office manager certification and award me the POMAA designation of Certified Practice Manager (CPM).

Applicants Name: _____

POMAA Member #: _____ Practice Name: _____

Practice Specialty: _____

Address: _____ City/State/Zip: _____

Practice Fax #: _____ Phone #: _____

CHECK ONE: Please mail related material to: Practice Address Home Address (fill in below if necessary)

Home Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone: _____

EXPERIENCE REQUIRED - You must be currently employed as a medical office manager, performing a scope of duties that qualify as a medical office manager for a minimum of one year. I am actively employed as a medical office manager: YES NO

Number of years experience as a medical office manager _____.

What medical office manager certification(s) do you currently hold? _____

Enclose a copy of your current medical office manager certification documentation. Submitted documents will not be returned.

I understand that the fee is \$75.00 to obtain the reciprocity recognition designation. This completed form along with proof of a current medical office manager certification must be faxed to 866-359-0561 if purchasing by credit card online by logging into POMAA's website.

Method of Payment: _____ Check _____ Money Order _____ Credit Card

Credit Card Type: _____ Master Card _____ Visa _____ Discover _____ Amex

Card Holder's Name: _____

Last

First

Credit Card Number: _____ Expiration Date: _____

MM/YY

SIGNATURE: _____ DATE: _____

Mail or fax entire package to: