

**PROGRAM APPLICATION
ASSE 6030 MEDICAL GAS VERIFIER PROGRAM**

Candidate Information

(Please Print)

NAME OF APPLICANT: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

Employment Information

(Please Print)

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____ DATE EMPLOYMENT STARTED: _____

Prerequisite Verification

Check ALL Boxes:

- I have (2) years of documented practical experience in the verification medical gas and pipeline distribution systems. Please attach documentation confirming experience.

Statement of Eligibility: I do solemnly swear and affirm that the information provided above is true. I further realize that providing false information shall be just cause for disqualification from the program. By affixing my signature to this application, I agree to abide by the program rules and requirements set forth above, and as a holder of a Medical Gas Training Institute certification I agree to abide by the Professional Standards of Conduct, and to not make any false claims about the scope of my certification(s). I understand that MGTI reserves the right to suspend or revoke my certification should I violate these obligations. Should my certification be revoked, I agree to cease and desist any and all references to being the "holder" of a MGTI certification and shall return any certificates, including wallet-sized photo identification cards, to MGTI. I also agree to not utilize any written documents, reports, procedures, etc. with the MGTI certification mark in any manner whatsoever that may be inaccurate.

SIGNATURE: _____ DATE: _____

PLEASE FAX COMPLETED PROGRAM APPLICATION FORMS TO [\(603\) 218-6262](tel:6032186262)
OR SCAN AND EMAIL TO SUPPORT@MEDGASINSTITUTE.COM