AMG
ACUTE MEDICAL GAS

470 MAST ROAD, SUITE B
GOFFSTOWN, NH 03045
PHONE: 603.487-3800
FAX: 603.218.6262

PROGRAM APPLICATION
ASSE 6030 MEDICAL GAS SYSTEMS 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

☐ I have two (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 the certifier 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
OR SCAN AND EMAIL TO TRAINING@ACUTEMEDGAS.COM