

From: Instructor Evaluator

Name	Organization	
Mailing Address	Business E-mail	
City	State/Province/Country	Zip

AMT has received an application for certification from the applicant listed below. Your cooperation in evaluating this candidate for certification with American Medical Technologists will be appreciated.

Applicant Name (please print)	AMT ID # (if known)
Date of Instruction: (Exact dates please) From (mm/dd/yy)	To (mm/dd/yy or current)