NITC
INSPECTION • TESTING • CERTIFICATION
ISO 9001:2015 Certified

6020 Medical Gas Inspector
Recertification Examination Request Form

(This request form is for the **2024** inspector written recertification).

✳ The fee per examination is $60.00 dollars. This must be prepaid. Please make a check or money order payable to NITC. Visa, Master Card or American Express is also accepted. The method of payment must be attached at the time of submission or contact NITC to provide credit card payment information by phone at (877) 457-6482. For NITC No-Show, Cancellation and Refund Policy refer to the Candidate Bulletin.

✳ **This request form must be submitted no later than three (3) weeks prior to the examination date.** Please e-mail to medgascerts@nationalitc.com.

✳ **All exams will be administered via computer.**

✳ A minimum of 10 examinees is required for an examination. I**f there are less than 10 examinees, a processing fee of $175.00 will be applied.**

Please complete all information below: (Required Fields**)**

*Name of Instructor: _____ **NITC ID #/UA ID #:** _____

*Examination Location: _____

*Examination Address: _____

*City, State, Zip: _____

*Contact Person: _____ Phone No: _____

*E-mail Results to: _____

*Date of Examination: _____ Time: _____ *Number of Examinees: _____

*Have all applicants completed a minimum 4-hour training course to the NFPA 99, 2024 edition Yes ☐ No ☐

* Will any additional examinations be given along with this examination? Yes ☐ No ☐

* Need NITC to find a proctor: Yes ☐ No ☐

Method of Payment
(**Required Fields for credit card payments**)

*Total Amount Enclosed: $ _____ Check ☐ Money Order ☐ Visa ☐ Master Card ☐ AMEX ☐

*Credit Card No: _____ *Expiration Date: _____

* CVV2: _____ *Last three or four digits on back of Visa and Master Card, Amex CVV2 on front of card.*

*Credit Card "*Billing Address*": _____ *Credit Card "*Billing Address*" Zip Code: _____

*Name on Card: _____ *Signature: _____
    As it appears on card (Please Print)   *Signature as shown on credit card*

Exam materials will be emailed to the proctor

Proctor's Name:	
Address:	
City, State, Zip:	
Cell Phone No:	Email:
Will the proctor waive his/her proctoring fees?	Yes ☐ No ☐

Please enter all the information completely for each applicant. Examinees who do **NOT** have an email address will not be sent their exam results.

Name:		SSN / UA #/ Cert ID #:	
Address:	City:	State:	Zip:
E-mail:		Phone #:	

Name:		SSN / UA #/ Cert ID #:	
Address:	City:	State:	Zip:
E-mail:		Phone #:	

Name:		SSN / UA #/ Cert ID #:	
Address:	City:	State:	Zip:
E-mail:		Phone #:	

Name:		SSN / UA #/ Cert ID #:	
Address:	City:	State:	Zip:
E-mail:		Phone #:	

Name:		SSN / UA #/ Cert ID #:	
Address:	City:	State:	Zip:
E-mail:		Phone #:	

Name:		SSN / UA #/ Cert ID #:	
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E-mail:		Phone #:	

Name:		SSN / UA #/ Cert ID #:	
Address:	City:	State:	Zip:
E-mail:		Phone #:	