



Director Certification Eligibility Application

Congratulations on taking the first step towards earning your MFA Medical Fitness Facility Director Certification!

Please complete the following application and save or scan the completed document with your name in the title of the file. Then email it to Mariann Murphy at mariann.murphy@medicalfitness.org. You may complete the work history and education in the form below or submit a resume with this application form. Once we have verified the information provided, we will contact you with the passcode to access the exam online.

If you have any questions, please contact us at 910-420-8610 M-F, 9a-5p ET or email David Flench, MFA President & CEO, at david.flench@medicalfitness.org.

APPLICATION

Name: _____

Position Title/How Many Years: _____

Organization/Facility: _____

Your Preferred Mailing Address: _____

City/State/Zip: _____

Email Address: _____

Phone Number: _____

Name of Current Supervisor: _____

Email Address of Current Supervisor:

Any Previous Name(s) Used for Work or Education:

EDUCATION

1 – University/College Name: _____

Degree Type and Title: _____

Month/Year Issued: _____

Registrar Contact Email or Phone #: _____

2 - University/College Name: _____

Degree Type and Title: _____

Month/Year Issued: _____

Registrar Contact Email or Phone #: _____

3 - University/College Name: _____

Degree Type and Title: _____

Month/Year Issued: _____

Registrar Contact Email or Phone #: _____

Accredited and Non-accredited Certifications

NOTE: We will use CREP to check accredited certifications – We only need the certifying organization for those credentials not accredited by either NCCA or ISO.

1 - Certification Name: _____

Is this Certification NCCA or ISO17024 Accredited? Yes No

Certifying Organization: _____

Contact Email or Phone #: _____

2 - Certification Name: _____

Is this Certification NCCA or ISO17024 Accredited? Yes No

Certifying Organization: _____

Contact Email or Phone #: _____

3 - Certification Name: _____

Is this Certification NCCA or ISO17024 Accredited? Yes No

Certifying Organization: _____

Contact Email or Phone #: _____

4 - Certification Name: _____

Is this Certification NCCA or ISO17024 Accredited? Yes No

Certifying Organization: _____

Contact Email or Phone #: _____

5 - Certification Name: _____

Is this Certification NCCA or ISO17024 Accredited? Yes No

Certifying Organization: _____

Contact Email or Phone #: _____

EMPLOYMENT

Please include your employment going back 10 years. If you have been with your current organization for 10 years or longer, please list only the positions held and dates of each.

1 - Employer: _____

City/State: _____

Dates of Employment: _____

Position(s) Held/Years in Position: _____

Current Supervisor or HR Representative: _____

Contact Email or Phone #: _____

2 - Employer: _____

City/State: _____

Dates of Employment: _____

Position(s) Held/Years in Position: _____

Supervisor or HR Representative: _____

Contact Email or Phone #: _____

3 - Employer: _____

City/State: _____

Dates of Employment: _____

Position(s) Held/Years in Position: _____

Supervisor or HR Representative: _____

Contact Email or Phone #: _____

4 - Employer: _____

City/State: _____

Dates of Employment: _____

Position(s) Held/Years in Position: _____

Supervisor or HR Representative: _____

Contact Email or Phone #: _____

5 - Employer: _____

City/State: _____

Dates of Employment: _____

Position(s) Held/Years in Position: _____

Supervisor or HR Representative: _____

Contact Email or Phone #: _____

If you need additional space, please attach a separate page.

Dear Director Credential Candidate,

In order to verify your eligibility to sit for the Medical Fitness Facility Director Certification exam, the MFA staff needs your permission to contact current and past:

- employers to verify your employment information,
- educational institutions to verify your degrees, and
- certifying organizations to verify your certifications.

By signing this form you agree to allow us to contact the organizations listed on this application to verify your eligibility to sit for our examination.

Printed Name: _____

e-Signature: _____

Date: _____