Certified Hyperbaric Technologist®
Recertification Form

Please include the following documentation with completed recertification form and return to NBDHMT headquarters.

- Proof of a minimum of 12 CEU hours within the past 2 years (A minimum of 6 CEUs MUST be Category "A", Hyperbaric Medicine). *
- A letter from applicant's affiliated institution verifying a minimum of 100 clinical work hours in the Hyperbaric Department within the past 2 years. *
- Payment to NBDHMT of the total amount due as calculated below.

National Board of Diving & Hyperbaric Medical Technology
9 Richland Medical Park, Suite 330, Columbia, SC 29203 USA
Phone: (803) 434-7802 Fax: (866) 451-7231
Email: nbdhmt@aol.com
www.nbdhmt.org

CHT® Number: _____

Last Name: _____ **First Name:** _____
Name as it appears on your government issued I.D.

Home Address: _____

City: _____ **State/Province:** _____ **Postal Code:** _____

Country: _____

Home Phone: _____ **Mobile Phone:** _____

Work Phone: _____ **Work Fax:** _____

Email: _____

Recertification Type

◯ CHT® ◯ CHT-ADMIN

* The requirements to show proof of 12 CEU hours, and verify 100 clinical work hours are waived, when applying to recertify as a CHT-ADMIN.

CHT-ADMINS: must include resume or C.V. with this application

Recertification Fees

Recertification Fee ($75.00 USD): _____

CHT Expiration Fee ($100.00 USD): _____

Background Verification Fee ($25.00 USD): $25.00

Total Due: _____

Criminal background check is required for all applicants for CHT status. Fees associated with this background verification are the responsibility of the CHT applicant.

Recertification is required every two years. If CHT certification lapses, certification may be obtained within one year from date of expiration. However, an additional fee of $100.00USD is charged.

If CHT certification has lapsed greater than one year, those CHT's who have maintained certification or licensure in a qualifying pathway may recertify by retaking the CHT examination.
All others will be required to begin an entirely new certification application.

Payment

◯ **Check or Money Order payable to NBDHMT** ◯ **Credit Card** ◯ **Visa** ◯ **Mastercard**

Card Number: _____ **Expiration Date:** _____

Cardholder Name: _____ **Zip Code:** _____

For Office Use Only:

Date Received: _____ ☐ Payment Enclosed ☐ Payment Cleared ☐ Background Verification Complete

☐ Data1 ☐ Data2

CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/ credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of **National Board of Diving & Hyperbaric Medical Technology (NBDHMT)** may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with **NBDHMT's** consideration of my certification and recertification through **NBDHMT**, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.

III. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

IV. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

V. I understand that if I am a resident of **Minnesota/Oklahoma (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box.

NOTE: A felony conviction will disqualify the applicant for a minimum of five (5) years from completion of sentence.

Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

CANDIDATE COMPLETE THE FOLLOWING:

Signature _____ _____
Please Print Full Name

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

_____ _____
Month, Day and Year of Birth Social Security Number

_____ _____ _____ _____
Home Address City State Zip

_____ _____
Driver's License Number and State Name as it appears on License

Have you ever been convicted of a crime? __ No __ Yes If yes, please provide city and state of conviction and details of conviction.

_____

_____

FAIR CREDIT REPORTING ACT NOTICE:
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state. Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by (INSERT COMPANY NAME) by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

National Board of Diving & Hyperbaric Medical Technology

Code of Conduct

The NBDHMT **Code of Conduct** represents a set of rules that collectively serve to outline the responsibilities of or proper practices for each Certified Hyperbaric Technologist.

Statement:

As a NBDHMT Certified Hyperbaric Technologist I, the undersigned, acknowledge and agree to honor my obligation to serve the highest standards of ethical conduct, integrity, and honesty. Further I agree that in the performance of my duties:

i. I will conduct myself in a manner that reflects positively on the NBDHMT and the hyperbaric medicine discipline in general
ii. I will refrain from behavior that harms the public and professional perception of the NBDHMT and the hyperbaric medicine discipline in general
iii. I will conduct my employment consistent with all applicable rules, regulations and laws which health care providers in general and hyperbaric medicine personnel in particular are subject
iv. I have read all of the NBDHMT published '*Position Statements*', understand their intent, and commit to remaining current as new '*Position Statements*' are promulgated
v. I will promote adherence to all relevant facility and patient safety aspects described within the NBDHMT's '*Position Statements*'

Name: _____ Date: _____

Signature: _____ CHT #:_____

Email: _____