

Certified Hyperbaric Veterinary Technologist®

Examination Registration Form

Include the following documentation with registration form and return to the NBDHMT

- A copy of vocation license or certification.
- A copy of approved Hyperbaric Medicine Training Course certificate.
- Written notification of the 40-hours Supervised Clinical Internship, including the name of the intern and name of the preceptor, along with signatures.
- A letter of recommendation from your Medical Director verifying a minimum of 480 hours of clinical Internship
- 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

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: _____

Institution or Affiliation: _____

Address: _____

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

Country: _____

Hyperbaric Training Program Attended : _____ **Date:** _____

Qualifying Vocation : _____

Vocation License/Certification Number : _____ **Issued By (State/Country) :** _____

Test Location Please visit www.NBDHMT.org for a complete Test Schedule.

☐ UHMS Annual Meeting ☐ UHMS Chapter Meeting: Specify Chapter : _____

Requested Test Location : _____ **Preferred Test Date:** _____

Registration Fees

Registration Fee (\$150.00 USD): _____

Retest (\$50.00 USD): _____

Background Verification Fee (\$25.00 USD): _____ \$25.00

Total Due: _____

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

If original CHT-VET certification has expired, applicant is responsible for the full registration fee of \$150.00USD plus the cost of background check.

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; or criminal/civil/driving record history. I understand that General Information Services, Inc., on behalf of **National Board of Diving and 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 .

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

CANDIDATE TO COMPLETE THE FOLLOWING:

Signature

Today's Date

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

Drivers License Number and State

Name as it Appears on Drivers License

Have you ever been convicted of a crime? ☐ Yes ☐ No 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 is 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 NBDHMT 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 Veterinary Technologist.

Statement:

As a NBDHMT Certified Hyperbaric Veterinary Technologist I, the undersigned, acknowledge and agree to honor my obligations to observe 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 to 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*'

Signature: _____

Date: _____

Name: _____

CHT #: _____

Email: _____

9 Medical Park, Suite 330 | Columbia, South Carolina 29203, USA

Tel: +1.803.434.7802 | FAX +1.866.451.7231

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