Instructor Medical Assistant Certification Critical Skill Competency/Qualification by Experience Documentation

2026

To Be Completed by the Applicant: (Please return form to NCCT with your application.)

Legal Name of Applicant _____

Today's Date (mm/dd/yyyy)_____NCCT User ID # _____

The remainder of this form must be completed by the applicant's direct patient care supervisor, which may include, but is not limited to, a licensed physician or primary care provider.

The person named above is applying for certification in the field of Medical Assistant. The application must have documentation reflecting a minimum of one (1) year full-time work experience as a Medical Assistant. In order to determine the eligibility of the applicant, we require verifiable documentation of knowledge, education, training, and proficiency in the critical skill areas as identified below. Please complete the documentation below. Only one (1) direct patient care supervisor per page.

Note: This page may be photocopied if more than one employer or direct patient supervisor will be verifying cases and providing documentation

Critical Skill Performance Competency	***Supervisor Initials***
Venipuncture	
Capillary puncture	
Medication Administration (to include injection, SQ, ID, IM)	
ECG Performance	
Sterile Technique *(to include all aspects of sterile technique such as hand hygiene, gloving, asepsis, sterile procedure set up and assist)*	
Vital Signs/Measurements *(to include daily, accurate performance of critical health measurements: B/P, R, P, T, Ht, Wt, BMI, Pulse Ox)*	

If this applicant was employed by your organization in a full-time capacity and that employment includes successful performance in these critical skills, please provide the dates of full-time employment (defined by NCCT as 40 hours per week). Each employer may only verify work experience performed at their own facility.

The applicant successfully performed the skills attested to through: ____ employment experience
start date _____ / _____ through _____ / _____ or _____ present.
month *year* *month* *year*

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (safe, consistent, and successful) in performing each of the critical skill areas as identified above. (Note: Actual patient care verification in an ambulatory care, medical office, or clinic environment is required - ***simulated clinical experiences or mannequin punctures do not meet qualification criteria***). Please verify competency by providing your initials next to each critical skill that you are attesting, within the Medical Assistant scope of practice/employment, according to individual state laws. Your signature and legible contact information are required for valid completion of this form.

Today's Date: (mm/dd/yyyy) _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Title _____

Supervisor/Verifier Printed Name _____

Supervisor/Verifier Signature _____

Company Name _____

Company Address _____City, State _____ Zip _____

Business Phone _____ Business Email _____

Note: The supervisor/verifier that signs this document must be able to be contacted.