

DPM Radiology Exam Registration Form

If you are a current member of the ASPMA (American Society of Podiatric Medical Assistants) you are eligible to take the Radiology Certification Exam.

Name _____

Address _____

City _____ State _____ Zip code _____

Phone number _____ fax number _____

Email _____ ASPMA # _____ APMA# _____

Exam Registration Fee **\$125.00**. An email with the Radiology Certification examination will be emailed to you with the exam instructions.

Mail registration form with a check made payable to ASPMA Qualifying and Examining to:

**ASPMA
1616 North 78TH Court
Elmwood Park, IL 60707
Phone: 888-882-7762**

**a \$25.00 fee will be charged for all returned checks*

OR

Fax registration form with credit card information and signature to: 708-456-4947

Circle one: Visa Mastercard Discover AmEx

Name on card: _____

Card number _____ exp: ____/____ CVV _____

Billing address _____

Signature _____