Mechanic Evaluation & Certification for Healthcare

MECH

RECERTIFICATION FORM

Name: _____
Healthcare Institution Name _____
Healthcare City _____ Healthcare State ____
Home Address _____
Home City _____ Home State ____
Email Address _____
Last 4 digits of SSN: _____ _____ _____ _____
MECH ID # (if known): _____

Instructions: *At the end of each one year anniversary period (certification month), fill out this form and file it in your personnel file. A minimum of 6 face-to-face hours of instruction must be documented and verified. At the end of 5 years (recertification period), mail all five copies (one per year) to MECH with your $60 recertification fee to:*

MECH, 4836 Green Moor Ct., Hudsonville, MI 49426

Topic		Date	Hours

Total Hours
(minimum of 6 hrs/yr)

Facility Manager/Engineer/Department Head Validation of Training
I have authorized the training listed above and have verified this attendance for the number of hours listed.

Name: _____

Title: _____

Date: _____

☐ $60.00 Fee Enclosed