

DAANCE Substitution/Cancellation Form



REQUEST TO RESCHEDULE TEST APPOINTMENT

Submit to PSI/AMP via:

- Mail: PSI/AMP, 18000 W. 105th Street, Olathe, KS 66061-7543
- Fax: 913-895-4650

Request for (check one): **Substitution** **Cancellation** **Rescheduling**

- To make a substitution, you must submit a completed Substitution/Cancellation Form accompanied by a completed DAANCE Registration Form (page 20) and a valid CPR and/or BLS card for the new registrant.
- Substitutions must be made a minimum of 30 days before the candidate's expiration of eligibility.*
- Cancellations will not be accepted after 90 days of candidate's activation.
- If a cancellation is made before 90 days, the sponsoring doctor will receive a refund equal to 50 percent of the registration fee.
- Rescheduled appointment dates must be before the candidate's expiration of eligibility. Note that rescheduling does not extend eligibility.*

REQUEST FOR CANCELLATION/SUBSTITUTION OR RESCHEDULING

Name _____

Candidate/DAANCE ID _____

Registrant (Substitute) to be enrolled:

Name _____

Candidate/DAANCE ID _____

Sponsoring Doctor

Sponsoring Doctor Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email _____

Signature of person requesting substitution or cancellation _____

Date _____

Please note: You will receive written confirmation regarding your request within 10 business days. If you do not receive written confirmation within that time period, please contact PSI/AMP at 888-519-9901.

REQUEST TO RESCHEDULE TEST APPOINTMENT

Candidates may reschedule ONE appointment within the eligibility period at no charge; a rescheduling fee of \$85 is required for any subsequent appointment change within the eligibility period. PLEASE NOTE: If this is your first request to reschedule your test appointment, you do not need to complete this form, but PSI/AMP must be contacted at least two business days in advance of your appointment date.

It is your responsibility to complete and submit the rescheduled or reapplication form to PSI/AMP within 30 days of the missed appointment.

Payment type: Check for \$85 enclosed Credit Card (MasterCard or Visa)

Credit Card # _____ Exp. Date _____

Name of Cardholder: _____

**Failure to comply will result in a candidate's registration being forfeited.*

detach here 