



Reaccreditation Instructor Form

Name _____ Title _____

Company Name _____

Address _____

City _____ State/Province _____ Postal Code _____

Phone (Office) _____ Cell _____ Email _____

To become reaccredited for a period of one year, an instructor must do ***one*** of the following:

1. Teach two or more classes within the 12-month accreditation period. A \$200 fee applies for instructors reaccreditation and AAMA will perform random on-site classroom audits during actual installer training courses.
2. Instructors who do not teach the minimum number of classes have the option of taking and passing the proctored instructor exam at an additional re-test fee of \$300 (total fee of \$500) prior to your expiration date.

Please indicate your selection and fill out the credit card authorization form on the next page. If option 2 is selected, please additionally fill out the Proctor form on page 3 of this document.

In the event that a trainer does not wish to continue training with InstallationMasters and would like to be removed from the mailing list, please notify AAMA at education@aamanet.org.

Signature

Date

Send to:
 American Architectural Manufacturers Association
 1900 East Golf Road Suite 1250
 Schaumburg, IL 60173
 Phone: 847-303-5664
 Fax: 847-303-5774
education@aamanet.org
www.InstallationMasters.com



Credit Card Payment Form

Date: _____

Please charge my credit card in the amount of: _____

American Express Master Card Visa

Credit Card #: _____

*CVV2 Code: _____ Exp Date: _____

**This is the three or four digit number printed on the back of the card.*

Name on Card: _____

Billing Address: _____

City: _____

State: _____ Zip: _____ Country: _____

Phone: _____ Fax: _____ E-Mail: _____

Cardholder Signature: _____

For Office Use Only

Invoice #: _____

AAMA Job #: _____

Approval: _____

Submitted by: _____

Send To:
American Architectural Manufacturers Association
1900 E. Golf Road Suite 1250
Schaumburg, IL 60173
Phone: 847-303-5664 Fax: 847-303-5774
education@aamanet.org
www.InstallationMasters.com

PROCTOR INFORMATION/VERIFICATION FORM

Accredited Instructor's Name: _____

Accredited Instructor's Telephone: (_____) _____

Proctor's Name: _____

Proctor's Company or Organization: _____

Job Title: _____

Address: _____

City, State, Zip: _____

Telephone: (_____) _____

Email Address: _____

Scheduled Date of Test*: _____

Scheduled Time of Test: _____

**Date must be scheduled allowing three weeks to receive materials. This is required information for generation of testing materials. Do not leave blank.*