

## Section II: Applicant Information



### **Important Note**

Name **MUST** match your government issued identification that will be presented at the testing center. Failure to do so will result in being denied exam access.

First (Given) Name \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

State/Province \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_ Email \_\_\_\_\_

Yes, I have a valid CTS certification and have no sanctions or pending investigations through the Certification Committee.

## Section III: Employment History

**Please complete employment history, latest experience listed first.**

**Most Recent Employer (1)** \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

State/Province \_\_\_\_\_ Country \_\_\_\_\_

Supervisor Name \_\_\_\_\_ Supervisor Title \_\_\_\_\_

Employment Dates \_\_\_\_\_ Your Title \_\_\_\_\_

Employer Phone \_\_\_\_\_ Employer Email \_\_\_\_\_

**Employer (2)** \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_

State/Province \_\_\_\_\_ Country \_\_\_\_\_

Supervisor Name \_\_\_\_\_ Supervisor Title \_\_\_\_\_

Employment Dates \_\_\_\_\_ Your Title \_\_\_\_\_

Employer Phone \_\_\_\_\_ Employer Email \_\_\_\_\_

## Section IV: Documentation of Experience



This section must be completed and signed if the candidate chooses to verify experience by employer. If you choose not to have your employer verify experience, you must provide alternate documentation of two years audiovisual installation experience. Examples would include redacted W2s, evaluations, client letters or similar documents

Current standards under which the CTS-I is accredited require that a candidate provide third-party validation that they have met the prerequisite of possessing a minimum of two (2) years of experience in the area of audiovisual installation.

If the verification of experience by employer option is chosen by the candidate, this form must be signed by the employer, supervisor, or HR department of the candidate's employer as verification as noted below:

I hereby affirm that the following candidate \_\_\_\_\_ (*Print candidate's name*) for the CTS-I examination has met the requirement of a minimum of two (2) years of installation experience in **audiovisual installation**. I also understand that applicants accepted as candidates and those certified as CTS-I have agreed to a Code of Ethics and Conduct and that providing false information on an exam application may result in an investigation and subsequent sanctions against the candidate by the Certification Ethics Committee that could include suspension of privileges as an applicant to apply for an AVIXA certification exam for a set period of time or suspension/removal of an existing certification.

Verifier's Name (Please print) \_\_\_\_\_

Title or position (Please print) \_\_\_\_\_

Company \_\_\_\_\_

Contact phone \_\_\_\_\_ Contact Email \_\_\_\_\_

Verifier's Signature \_\_\_\_\_ Date signed \_\_\_\_\_

## Section V: Applicant Special Accommodations Request

Please check **Yes** or **No**:     Yes             No

*If yes, you must complete the Request for AVIXA Examination Special Accommodations AND Healthcare Documentation of Disability Related Needs forms in the CTS Candidate Handbook online at [www.AVIXA.org/cts](http://www.AVIXA.org/cts) and mail to the certification office a **minimum of 45 days** prior to your desired testing date.*

## Section VI: Agreement and Signature

By checking the box and by typing or signing my name in the space provided, I agree to the following:

- I authorize the Certification Committee to obtain any background information necessary to verify the accuracy and completeness of my responses to all questions contained herein.
- I understand that the Certification Committee may audit candidate applications to verify experience or education either prior to or after an examination is taken, or after the results are announced. I agree to cooperate with such audit and further understand that providing false information for verification of experience or education, or having others to do so is a violation of the Certified Technology Specialist Code of Ethics and Conduct and may result in sanctions.
- I hereby certify that I have read all portions of this application and the CTS-I Candidate Handbook and believe myself to be in compliance with all admission policies related to the CTS-I examination. The information I submit on this application and any documents I have enclosed or forwarded are complete, true and correct to the best of my knowledge and belief.
- I agree to immediately inform the certification office of all changes to the information included in this application while I am an applicant, and for as long as I am certified by the Certification Committee.
- I hereby attest that I am signing, either in person or electronically if by other than mailed application, and that I will be the individual taking the CTS-I examination I have applied for, solely for the purposes of CTS-I certification. I further understand that I am prohibited from transmitting information regarding examination questions or content in any form to any person or entity, and understand that failure to comply with this prohibition may result in my certification being revoked and/or legal action being taken against me.
- I have read, understand, and agree to be bound by the certification-related policies and procedures and Certified Technology Specialist Code of Ethics and Conduct promulgated by the Certification Committee. I understand and agree that my failure to abide by the Certification Committee's policies and procedures and Certified Technology Specialist Code of Ethics and Conduct shall constitute grounds for rejection of my application or denial or revocation of my certification.
- I understand that if successful I will be listed in the online professional certification registry; however if in the future if I should not want to continue to be listed in the online registry, that I should send an email request stating such to [certification@AVIXA.org](mailto:certification@AVIXA.org) or fax/mail the request to the certification office. I understand that even if my credentials are not listed in the online directory AVIXA will continue to verify credentials upon request.
- I agree to give the Certification Committee, and its agents and contractors, permission to contact me by U.S. mail, electronic mail, facsimile, or through other media on matters that AVIXA believes may be of importance to me. Should I wish to be taken off the certification mailing list in the future, I will send an email request stating such to [certification@AVIXA.org](mailto:certification@AVIXA.org), or fax/mail the request to the certification office.

I have read, understand, and agree to the terms listed above.

Please check the box and personally sign or type name and date below as your electronic signature of agreement if this application is submitted other than by mail.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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NOTE: Applicants and stakeholders should download the most up-to-date free edition of the CTS-I Candidate Handbook that may include important policy and procedure updates by going to the AVIXA website at [www.AVIXA.org](http://www.AVIXA.org). Date of this version is 01/01/20 ©2020 AVIXA®

## Section VII: Examination Fees and Payment Method

<i>NOTE: Applicable VAT and taxes are NOT included</i>	<i>USD Paid Member</i>	<i>USD Non-Member</i>	<i>Euro Paid Member</i>	<i>Euro Non-Member</i>	<i>GBP Paid Member</i>	<i>GBP Non-Member</i>	<i>AUD Paid Member</i>	<i>AUD Non-Member</i>
<b>CTS-I</b>	490	590	440	530	380	455	655	790
<b>Developing Country CTS-I</b>	245	295	220	265	190	230	330	395

**Refunds will not be provided to candidates who fail to verify membership level prior to purchase**

**Note:** Applications will not be processed unless accompanied by a payment for the correct amount, signatures and any attachments required as a part of the eligibility requirements.

**Please indicate payment currency:**  USD  GBP  Euro  AUD

**Please indicate payment method:**

I have enclosed a check or money order payable to AVIXA for the appropriate amount as listed above.

**OR**

I authorize AVIXA to charge my credit card in the amount of \_\_\_\_\_

For credit card purchases, please email your application to [certification@avixa.org](mailto:certification@avixa.org) for processing. Once your application has been received and approved, you will receive an email from [certification@avixa.org](mailto:certification@avixa.org) that will contain a personalized payment link to AVIXA's secured payment portal. AVIXA does not accept credit card numbers via email, all credit card transactions must be completed online using our secured payment portal.

**OR**

By wire transfer:

**Note:** Wire transfers are acceptable methods of payment, however, added processing time and additional bank fees may occur as a result. The applicant is responsible for any bank fees.

I have sent a wire transfer to AVIXA in the amount of \_\_\_\_\_

Wire transfer #: \_\_\_\_\_

**OR**

I have a certification gift card

Gift Card #: \_\_\_\_\_

**Mail, fax, or email this application to the following addresses:**

AVIXA, Attn. Certification Office  
 11242 Waples Mill Rd., Suite 200, Fairfax, VA 22030  
 1.800.659.7469 or +1.703.273.7200  
 +1.703.991.8259 Fax  
[certification@AVIXA.org](mailto:certification@AVIXA.org)

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## Appendix C: Special Accommodations

### Request for AVIXA (CTS, CTS-D, CTS-I) Exam Special Accommodations

If you have a disability covered by a national disabilities program (e.g., Americans with Disabilities Act), and you wish to request accommodation for a qualified disability, please complete this form AND the *Healthcare Documentation of Disability Related Needs Form* so your request can be processed efficiently. The information you provide, along with any documentation regarding your disability and your need for accommodation in testing, is strictly confidential.

#### Applicant Information:

First (Given) Name \_\_\_\_\_ Last (Family) Name \_\_\_\_\_  
Address 1 \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_  
State/Province \_\_\_\_\_ Country \_\_\_\_\_  
Phone \_\_\_\_\_ FAX \_\_\_\_\_ Email \_\_\_\_\_

### Special Accommodations

I request special accommodations (please indicate in the table below), for the (preferred date of exam) \_\_\_\_\_ administration of the Certified Technology Specialist (CTS, CTS-D or CTS-I) Exam. I understand that the AVIXA Certification Committee may require a fee to defray the costs of these accommodations, as may be permitted by law.

Please provide (check all that apply):

- Accessible testing site
- Separate testing area
- Special seating
- Reader
- Extended testing time (time and a half)
- Other ADA special accommodations as authorized by a qualified medical professional (please specify): \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_

*Return this form with your exam application information to the certification office **a minimum of 45 days** prior to the date you wish to take the exam. This request will not be processed if it is not accompanied by a properly completed AVIXA Exam Documentation of Disability Related Needs Form (Appendix D).*

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## Appendix D: Healthcare Documentation

### AVIXA (CTS, CTS-D, CTS-I) Exam - Healthcare Documentation of Disability Related Needs

This section must be completed by a licensed healthcare provider who has been personally involved in the diagnosis or treatment of the disability for which you are requesting accommodation, OR an educational or testing professional who has previously provided you with testing accommodations similar to those requested. This form must accompany the Request For AVIXA (CTS, CTS-D, CTS-I) Exam Special Accommodations Form.

#### Professional Documentation

I have known \_\_\_\_\_ (Exam Applicant's Name) since \_\_\_\_\_ (Date) in my capacity as a \_\_\_\_\_ (Professional Title)

The applicant has discussed with me the nature of the exam to be administered. It is my opinion that, because of this applicant's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

License # (if applicable) \_\_\_\_\_

*Return this form with your exam application information and the "Request for AVIXA (CTS, CTS-D, CTS-I) Exam Special Accommodations" to the certification office a **minimum of 45 days** prior to the date you wish to take the exam. Please call the AVIXA Certification Office, if you have any questions about procedures in completing this application.*

AVIXA, Attn. Certification Office  
11242 Waples Mill Rd., Suite 200  
Fairfax, VA 22030