



9-YEAR RE-CERTIFICATION COURSE (RSV)

PLEASE PRINT IN BLUE OR BLACK INK

P.O. Box 440367 ♦ Miami, FL 33144-0367 ♦ (800) 443-9353, ext. 273 ♦ (305) 443-9353, ext. 273

Form with sections: ARE YOU A CURRENT AWS MEMBER, METHOD OF PAYMENT, AWS Use Only, and a deadline notice: *THE APPLICATION SUBMISSION DEADLINE IS(6) WEEKS PRIOR TO THE SCHEDULED TEST DATE

Form for personal information: LAST NAME, FIRST NAME, MI, U.S. SOCIAL SECURITY NUMBER, INTERNATIONAL CANDIDATE PASSPORT NUMBER

PLEASE REGISTER ME FOR THE 9-YR RE-CERTIFICATION COURSE (6-DAY COURSE)

- Monday – Friday, 8am – 10pm AND
Saturday, 8am – 5pm

DISCLAIMER: AWS reserves the right and the discretion to cancel any Re-Certification Course. In the event of a cancellation by AWS, the customer will be re-scheduled to an alternate location or will be refunded all fees. AWS shall have no further liability.

Form for site and test date information: 1st Site Code, Test Date, City/State, Application Submission Deadline

PLEASE ORDER A REPLACEMENT SCWI OR CWI STAMP WITH MY RENEWAL CERTIFICATION YES NO
ENCLOSED IS AN ADDITIONAL \$30.00. NO CAWI STAMPS ARE AVAILABLE. If you do not receive your CWI stamp (3) weeks after your CWI certificate and wallet card, please contact the Certification Business Unit at:1-800-443-9353, ext. #273.

PLEASE NOTE: THE 9-YR RE-CERTIFICATION COURSE MUST BE TAKEN PRIOR TO YOUR CERTIFICATION EXPIRATION DATE. Your CWI or CAWI will be restored for an additional (3) YEARS once your have successfully completed the 9-Year Re-Certification Course. Neglecting to re-certify PRIOR to your expiration will result in the loss of your certification status. In order to regain your certification, you must re-test on all (3) parts of the CWI/CWE Exam.

LAST NAME:

FIRST NAME:

QUALIFYING WORK EXPERIENCE – NO RESUMES ACCEPTED

(initials) I understand that all work experience documented on this application may be verified with both past and present employers.

Duplicate this page as needed to provide additional information for each one of your employers in order to meet the experience requirements for 9-Year Re-Certification.

Company Name: _____ Dept/Div: _____

Supervisor/Personnel Manager: _____ Telephone: (____) _____

Mailing Address: _____

City: _____ ST/Prov: _____ Zip: _____ Country: _____

Supervisor/ Personnel Manager's E-mail: _____

JOB TITLE	FROM MONTH/YEAR	TO MONTH/YEAR
1)		
2)		
3)		
4)		
5)		
6)		

EMPLOYMENT VERIFICATION

PLEASE HAVE THIS SECTION COMPLETED BY YOUR SUPERVISOR OR PERSONNEL MANAGER OF YOUR MOST RECENT EMPLOYER. IMPORTANT. THIS PAGE MUST BE MAILED WITH YOUR APPLICATION. DO NOT SEND SEPARATELY. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS COMPLETED SECTION. DO NOT USE THIS SECTION IF SELF EMPLOYED. SELF EMPLOYED APPLICANTS MUST PROVIDE TWO (2) NOTARIZED LETTERS OF REFERENCE FROM SEPARATE CLIENTS.

Employee's last name: _____ First name: _____ MI: _____

Company Name: _____ Dept/Div: _____

Mailing Address: _____

City: _____ ST/Prov: _____ Zip: _____ Country: _____

Supv/ Personnel Mgr E-mail: _____ Supv/Personnel Mgr Phone: (____) _____

PLEASE PRINT EXCEPT FOR SIGNATURE

I verify that: _____, whose social security number is: _____ is / was (circle one)

employed by this company and conducted the duties submitted in this application during the employment periods submitted

in this application. My name is: _____ My job title is: _____

Date: _____ Signature: _____

PROVISO: Upon obtaining my certification, I give AWS the right to reveal my certification status as it relates to my validity and expiration date only. No other information related to my certification shall be revealed. Yes No

NOTARIZATION. –APPLICATION MUST BE NOTARIZED.

I hereby certify that I have read the requirements contained in the document QC-1 Standard for AWS Certification of Welding Inspectors. Further, I agree to comply with the existing requirements and any subsequent requirements that may be instituted by AWS. I certify that the information I have included on this application is true; I understand that any false statements will nullify this application. I give AWS permission to verify this information. I agree to comply with the provisions set forth in the Standard concerning the administration of my examination and certification.

Applicant's Signature _____ Sworn to and subscribed before me this ____ day of _____ 200__

My commission expires _____ Notary Public Signature _____ (Seal and/or stamp is required)



Visual Acuity Record

PLEASE PRINT IN BLUE OR BLACK INK

ATTACH THIS COMPLETED RECORD TO YOUR MAIN APPLICATION

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NAME OF APPLICANT: _____ SOCIAL SECURITY NUMBER: _____
(or international passport number)

CERTIFICATION NUMBER (IF CERTIFIED): _____ EXAM DATE/LOCATION: _____

TO ALL CERTIFICATION EXAMINATION CANDIDATES:

You **must** use the services of an Ophthalmologist, Optometrist, Medical Doctor, Registered Nurse, or Certified Physician's Assistant to administer **your required** eye examination. The examination must occur **within the seven (7) months prior to the scheduled date** of the applicant's welding inspection examination or re-certification anniversary date. Please attach this completed record to your main application and send to AWS, and **keep a copy for your files**.

All applicants must pass an eye examination, **with or without** corrective lenses, to prove near vision acuity on Jaeger J2 at 12 in. to 17 in (30.48cm to 43.18cm). All applicants shall take a color perception test. Eye examination results shall be submitted on record forms furnished by the AWS Certification Business Unit.

AWS will not accept visual acuity test results that do not comply with regulations. AWS will not release your exam results without a completed visual acuity record on file. Applicants may submit completed visual acuity records at the exam location.

TEST RESULTS

Applicant possesses near vision acuity on Jaeger J2 (letters .37cm in size) at a distance of 12 in. to 17 in. (30.48cm to 43.18cm)?

- WITHOUT CORRECTION (O*)
- WITH CORRECTION (W*)

Through a color perception examination, has it been determined that the applicant is colorblind?

- YES (B*)
- NO (C*)

*FOR CERTIFICATION INTERNAL PURPOSES.

ATTEST TO

I certify that I, _____ administered an eye examination to the
(print eye examiner's name)
applicant _____ on _____ which
(print applicant's name) (date)

demonstrated the vision capabilities indicated above.

PLEASE IDENTIFY YOUR PROFESSIONAL STATUS BY CHECKING ONE OF THE FOLLOWING:

- Ophthalmologist
- Optometrist
- Medical Doctor
- Registered Nurse
- Certified Physician's Assistant

STATE/PROV. LICENSE NUMBER: _____

PROFESSIONAL MAILING ADDRESS: _____

CITY: _____ ST/PROV.: _____ ZIP: _____ COUNTRY: _____

SIGNATURE OF EYE EXAMINER: _____ CONTACT TELEPHONE NUMBER: () _____