CFM® Exam RETAKE APPLICATION

Mr./ Ms. (Circle)

Last Name    First    Middle Initial

Email: ___________________________________________________    Date of Birth ________________________________

Phone: ___________________________  Employer: _____________________________________________________________

Address: __________________________________________________________________________________________

Signature: ____________________________________________________________________________  *Required*

Location and Date of Exam applying for: ________________________________________________________________

FEES:

*Re-examination Fee $ 50

_____ Check enclosed _____ VISA or MasterCard _____ Purchase Order

Check or Purchase Order Number ________________________________

PAYMENT AMOUNT TOTAL $ ______________

Card # ____________________________  Expiration Date ____________  CCV # ______________

Card Holder's Name ____________________________  Cardholders Zip Code __________

SIGNATURE ____________________________________________

Retake exam fee only applies within 12 months of initial exam or at the next conference, whichever is later. Otherwise, applicant must re-submit original application and original fees.

When an applicant cancels from a scheduled exam, with at least two weeks notice to the ASFPM Executive Office, he/she will receive a 50% refund. No refund will be given if the cancellation occurs with less than two weeks notice. Rescheduling to a future exam site and date is acceptable with no penalty within one year.

Mail to: ASFPM, 8301 Excelsior Dr., Madison, WI 53717
Phone: 608-828-3000  Fax: 608-828-6319