



INTERNATIONAL COMMISSION  
ON HEALTH CARE CERTIFICATION

**ICHCC Application Form for the  
Certified Geriatric Care Manager Credential**

Name: \_\_\_\_\_, First \_\_\_\_\_ MI \_\_\_\_\_

Business Address: \_\_\_\_\_

City State & Zip \_\_\_\_\_, \_\_\_\_\_

Business Telephone: (\_\_\_\_) \_\_\_\_\_ Business Fax: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Mailing Address (if different from above):  
\_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_, Zip: \_\_\_\_\_

**1. Education**

**Please attach a copy of your educational degree(s) and any other credential you wish to have recognized by the Commission.**

Education Degree (Letter Designation:

Bachelors \_\_\_\_\_

Nursing \_\_\_\_\_

Masters \_\_\_\_\_

Doctoral \_\_\_\_\_

**Education Institution:**

Bachelors \_\_\_\_\_

Nursing \_\_\_\_\_

Masters \_\_\_\_\_

Doctoral \_\_\_\_\_

2. **Employment History** (Only apply the past 5 year work period)

Years Employed in ANY Professional Setting Since Attainment of Degree: \_\_\_\_\_

**A. Professional Title and Current Employment Position:** \_\_\_\_\_

\_\_\_\_\_

Employer/Corporation Name: \_\_\_\_\_

Time Employed with Current Employer \_\_\_\_\_

**B. 2nd Most Recent Employment/Professional Title:** \_\_\_\_\_

\_\_\_\_\_

Employer/Corporation Name: \_\_\_\_\_

Time Employed with Current Employer \_\_\_\_\_

**C. 3rd Most Recent Employment/Professional Title:** \_\_\_\_\_

\_\_\_\_\_

Employer/Corporation Name: \_\_\_\_\_

Time Employed with Current Employer \_\_\_\_\_

**3. Continuing Education Units/Training**

Include training and education units acquired within the last 5 year period. Course or verification forms are required for each documented training program/course. A minimum of 120 hours is required to satisfy this section of the application. If applying as a graduate of the University of Florida, Capital, or the Kaplan program, a copy of your certificate of completion should be attached.

**1) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** \_\_\_\_\_**2) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** \_\_\_\_\_**3) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** \_\_\_\_\_**4) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** \_\_\_\_\_

5) **Program Title:**

**Date Attended:**

**Number of Units Awarded:**

**Awarding Board Name:** \_\_\_\_\_

6) **Program Title:**

**Date Attended:**

**Number of Units Awarded:**

**Awarding Board Name:** \_\_\_\_\_

7) **Program Title:**

**Date Attended:**

**Number of Units Awarded:**

**Awarding Board Name:** \_\_\_\_\_

8) **Program Title:**

**Date Attended:**

**Number of Units Awarded:**

**Awarding Board Name:** \_\_\_\_\_

9) **Program Title:**

**Date Attended:**

**Number of Units Awarded:**

**Awarding Board Name:** \_\_\_\_\_

10) **Program Title:**

**Date Attended:**

**Number of Units Awarded:**

**Awarding Board Name:** \_\_\_\_\_

**Use Back if Necessary**

**4. Testing Information**

Testing is administered online and on-site. If you plan to take the exam online, you will need to provide the name, phone number, address and e-mail address of a proctor as well as a testing site where you will be accessing the Internet. The exam must be taken at a university, community college, Sylvian Learning Center, or public library. The password key will be sent to your proctor, and the proctor will supervise your testing experience.

**Proctor Name:** \_\_\_\_\_

**Exam Site:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Proctor E-mail:** \_\_\_\_\_

**If you are taking the exam on-site, either at the ICHCC main office or at a designated national site, please indicate the date and location below.**

**Exam Date:** \_\_\_\_\_

**Exam Site:** \_\_\_\_\_

**5. Exam Fees**

Please attach a check or money order made payable to **ICHCC** totaling **\$445**. You may use your credit card by accessing the Secure-Pay application located on the ICHCC web site at [www.ichcc.org](http://www.ichcc.org). Please forward your notice for testing and payment to:

**The International Commission on Health Care Certification (ICHCC)**

**13801 Village Mill Drive**

**Suite 103**

**Midlothian, VA 23113**

**Phone Number: (804) 378-7273**

**Fax: (804) 378-7267**

**PLEASE PRINT NAME AND CREDENTIALS EXACTLY ON THE LINE BELOW AS THEY SHOULD APPEAR ON YOUR CERTIFICATE**

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