ICHCC Application Form for the
Certified Healthcare Risk 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. <u>**Education**</u>
   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 60 hours is required to satisfy this section of the application. If applying as a graduate of the University of Florida's continuing education program in healthcare Risk Management, simply attach a copy of your certification of completion and skip to number 4 – Testing Information, page 5**

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. 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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