



INTERNATIONAL COMMISSION  
ON HEALTH CARE CERTIFICATION

**ICHCC Application Form for the  
Certified Life Care Planner 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: \_\_\_\_\_

**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**. If you have not had one of your life care plans peer-reviewed by the training program from which you obtained your 120 hours of life care planning training, please submit an additional **\$250** to have it peer-reviewed by the ICHCC CLCP Commissioners. 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**

---