CERTIFIED GERIATRIC CARE MANAGER™ (CGCM®) APPLICATION CHECKLIST

Please use the following form to assist with your application for the **CGCM®** credential. Copies of the following must be included with your application. Please note that these will not be returned to you.

- ☐ Fully Completed Application
- ☐ Copy of diploma from college or university
- ☐ Copy of certificate from approved training course(s)
- ☐ Resume or Curricula Vitae
- ☐ Test Fee is payable to **ICHCC®** at ichcc.org

Applications may be faxed, mailed, or emailed to:

ICHCC®
13801 Village Mill Drive, Suite 103
Midlothian, VA 23114
Office (804) 378-7273
Fax: (804) 378-7267
Email: ichcc1@gmail.com

ICHCC®
INTERNATIONAL COMMISSION ON HEALTH CARE CERTIFICATION®

APPLICATION FOR CERTIFICATION
Certified Geriatric Care Manager™

INSTRUCTIONS Date: _____

Print and complete all items that apply to you. Please DO NOT STAPLE. Make sure all documents are submitted with your application. Please note that these items will not be returned to you.

Please write clearly and legibly.

APPLICANT INFORMATION

Name_____

Address _____

City _____State _____ Zip_____

Phone _____Email_____

Mailing Address (if different from above):

Address _____

City _____State _____ Zip _____

EDUCATION INFORMATION

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

	College/University	Degree Awarded
Bachelor's	_____	
Master's	_____	
Doctoral	_____	
Nursing	_____	

____ Diploma-RN ___ Associates-RN ___ BSN-RN ___ MSN-RN

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ADDITIONAL CERTIFICATIONS

Please use the space below for additional certifications or credentials awarded. A copy of the credential must be attached.

Designation	Acronym	Expiration Date

EMPLOYMENT HISTORY

Please list by most recent. Include only the past five years of employment. Attach additional information if necessary.

Current Professional Title_____

Employer Name_____

Address _____

City _____State _____ Zip_____

Phone _____ Time Employed _____

Professional Title _____

Employer Name_____

Address _____

City _____State _____ Zip _____

Phone _____ Time Employed _____

ICHCC® APPROVED CGCM® TRAINING INFORMATION

A minimum of 40 hours is required to satisfy this section of the application. A copy of your Certificate of Completion must be attached from an ICHCC® approved training program. Certification must be within five years of the graduation date.

40-hour CGCM Program Attended: _____

Completion Date: _____

TESTING INFORMATION

Review the Examination Testing section of the Candidate Handbook for additional information on options for scheduling your exam. Please allow a minimum of 7 business days to process your application.

Our online administration of the examination is proctored by Prov✓. Once your CGCM® application is approved, you will be sent an application approval letter from the ICHCC® as well as an Exam Voucher from **nonreply@provexams.com.** Your Exam Voucher will contain your Candidate ID number, contact information for Prov✓, as well as additional information on the CGCM® examination. When you receive your Exam Voucher, you may call Prov✓ to schedule your CGCM® exam date and time. Prov✓ will charge you a $30 proctoring fee, which will be paid directly to them. Exam results will be provided within 24 to 36 hours.

EXAM FEES

- **Certified Geriatric Care Manager™ Examination** Fee: $495

Payments by check or money order should be made payable to ICHCC®. Credit card payments may be processed online at ichcc.org. **Payments outside the United States must be paid by credit card.**

To Pay Online:

1) Go to the ICHCC.org website; 2) Choose the shopping cart icon in the top right-hand corner of the page; 3) Choose CGCM® Products; 4) Choose the "CGCM® Application" fee and add it to your cart; 5) Scroll up the page and choose "Checkout."

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DISCLAIMER AND SIGNATURE

I HEREBY CERTIFY that the facts set forth in this application for the **Certified Geriatric Care Manager™** credential are true and complete to the best of my knowledge. I understand that if I am certified, false statements on this application shall be considered sufficient cause for dismissal and revocation of my credential. I authorize the **International Commission on Health Care Certification™** to provide validation to any organization on my certification status upon request.

I have read and fully understand the contents of this handbook and will abide by the standards and guidelines set forth by the Commission.

_____ _____

Signature Date

_____

Printed

Below, please print your name and credentials exactly as they should appear on your certificate:

_____

OPTIONAL:

The following is not required and is used for statistical analysis only.

Number of years since acquired degree: ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ 15-19 ☐ 20-25 ☐ 26+

Number of years employed in the Health care Field: ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ 15-19 ☐ 20-25 ☐ 26+

Age ☐ under 25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐41-45

☐46-50 ☐ 51-55 ☐ 56-60 ☐ 61+

Gender ☐ Female ☐ Male

Ethnicity ☐ African American ☐ Asian ☐ Hispanic

☐ Native American ☐ White ☐ Other