

CERTIFIED MEDICAL COST PROJECTION SPECIALIST™ (CMCPS®) APPLICATION CHECKLIST

Please use the following form to assist with your application for the **CMCPS®** 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 completed approved training course(s)
- ☐ Resume or Curricula Vitae
- ☐ Copy of your sample medical cost projection that was submitted for peer review
- ☐ Copy of the peer-review critique of your sample medical cost projection
- ☐ Copy of credential certificate or license
- ☐ 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](mailto:ichcc1@gmail.com)



APPLICATION FOR CERTIFICATION

Certified Medical Cost Projection Specialist™ (CMCPS®)

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

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 CMCPs® TRAINING INFORMATION

The Certificate of Completion from your ICHCC® approved CMCPs® training program must be attached. CLCP®s and CCLCP™s must only attach the Certificate of Completion for Module 7 and the peer review of their medical cost projection.

CMCPs® Training 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 CMCPs® 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 CMCPs® examination. When you receive your Exam Voucher, you may call Prov✓ to schedule your CMCPs® exam date and time. Prov✓ will charge you a \$30 proctoring fee, which will be paid directly to them. Exam results will be available within 24 to 36 hours.

EXAM FEES

- **Certified Medical Cost Projection Specialist™ 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.

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 CMCPs® Products; 4) Choose the "CMCPs® Application" fee and add it to your cart; 5) Scroll up the page and choose "Checkout."

DISCLAIMER AND SIGNATURE

I HEREBY CERTIFY that the facts set forth in this application for the **Certified Medical Cost Projection Specialist[™]** 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.

The ICHCC[®] Administration may, upon review of supporting documentation, approve professional experience and education not specifically identified under qualifications. Final acceptance and approval of all certification applications will be the decision of the ICHCC[®] Administration and will not be eligible for appeal.

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