INTERNATIONAL COMMISSION
ON HEALTH CARE CERTIFICATION

APPLICATION CHECKLIST

Please use the following form to assist with your application for the MSCC 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

☐ Copy of certificate from completed training course(s)

☐ Curricula Vitae

☐ MSA Work Sample

☐ Test Fee of $445 payable to ICHCC

*If your program did not require you to submit a work sample (MSA), then you must complete one for review by the CLCP Board of Commissioners before you can sit for the examination. Our office will provide you with a sample case for which you will write MSA work sample based on the medicals you receive specific to the case. A $250 fee will be charged for the peer-review. Please contact our office at (804) 378-7273 for additional information.

Applications may be faxed or mailed to:

ICHCC
13801 Village Mill Drive, Suite 103
Midlothian, VA 23114
f: (804) 378-7267

Credit card payments may be processed online at ichcc.org. Payments outside of the US must be by money order or cashier's check in United States Dollars, payable to ICHCC.

We look forward to the many possibilities ahead for you. Should you have any questions, please feel free to contact us at (804) 378-7273.

With best regards,

The International Commission on Health Care Certification

INTERNATIONAL COMMISSION
ON HEALTH CARE CERTIFICATION

APPLICATION FOR CERTIFICATION

Medicare Set-Aside Certified Consultant

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.

APPLICANT INFORMATION

Name ____

Address ____

City ____ State ______ Zip ___________

Phone ____________________________ Email ___________________________________

Mailing Address (if different from above):

Address ____

City ____ State ______ Zip ___________

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 Healthcare 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

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 following 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 ______________________________

Professional Title ______________________________

Employer Name ______________________________

Address ______________________________

City ______________________________ State ________ Zip ______________

Phone ______________________________ Time Employed ______________________________

Continuing Education Units and Training

A minimum of 30 hours is required to satisfy this section of the application. A copy of your certificate of completion must be attached for each documented training program/course relating to MSA. Certification must be obtained within five years from graduation date.

Program Attended: ______________________________

Graduation Date: ______________________________

EXPERIENCE IN MSA CONSULTATION SERVICE DELIVERY

Please describe your exposure or experience in developing Medicare Set-Aside Arrangements below, whether as a consultant or as a primary negotiator. Attach additional information if necessary.

Testing Information

Examination Testing information options are described below.

Option 1:

Our online administration of the examination is proctored by ProctorU. To register, please visit www.proctoru.com. Exam site is at the applicant's discretion. Please note that ICHCC will contact you when your exam is available after you have registered with ProctorU.

Requested Exam Date ______________________________________

Option 2:

Exam must be taken at a university, community college, Sylvan Learning Center, or public library. The password key will be sent to your proctor, and the proctor will supervise your testing experience.

Exam Site ______________________________________

Exam Date ______________________________________

Proctor Information:

Name ____

Address ____

City ______________________________________ Province _______ Postal Code _______________

Phone ________________________________ Email _______________________________________

Exam Fees

Medicare Set-Aside Certified Consultant Examination Fee: $445

Payments by check or money order should be made payable to ICHCC. Credit card payments may be processed online at ichcc.org. Payments outside of the US must be by money order or cashier's check in United States Dollars, payable to ICHCC.

DISCLAIMER AND SIGNATURE

I HEREBY CERTIFY that the facts set forth in this application for the Medicare Set-Aside Certified Consultant 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 Commission on Health Care Certification to provide validation to any organization on my certification status upon request.

I have read and fully understand the standards and guidelines of the ICHCC, and will abide by those standards and guidelines set forth by the Commission.

____ ______________________________

Signature Date

____

Printed

Please print name and credentials exactly as they should appear on your certificate below:

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