

Name: \_\_\_\_\_

## **APPLICATION FOR RENEWAL**

Certified Medical Cost Projection Specialist					
Date					
Name		Certificate Number			
Street Address	City	State	Zip		
Phone	E	Email			
On the line below, please list y	your name as you wish to ha	ve it read on your c	ertificate:		
The ICHCC requires 15 Continuing Educ (5) of these 15 required hours must rel preapproved. Should any course be no Applications may be faxed to (804) 378	ate to Ethics. The recertification-preapproved, a recertification- 3-7267, or emailed to ichcc1@	tion fee is \$300 if all tion fee of \$350 mu Ogmail.com, or mail	I courses are st be submitted.		
International	Commission on Health Care 13801 Village Mill Drive	Certification			
	Suite 103				
	Midlothian, VA 23114				
*Payments outside of the United State Dollars, payable to ICHCC. Credit card the invoice that will automatically be se  Please use the following form to ide Copies of the attendance verificatio Please note	payments may be processed ent to your email address the entify the CEU's you are using	online at ichcc.org on the ichcc has on file.  Ichcc has on file.	or by paying using CPS credential.		
If any of the CEU's are not preapprov conference information must be attaced in Completion if We look forward to our continued related to the continued related in the continued related related related related related related related related relat	ched for review by the ICHCC a course was preapproved b	c. It will state on you y the ICHCC.	ur Certificates of		
to contact us at (804) 378-7273.  13801 Village Mill Drive, Suite 10					
13001 Village IVIIII Drive, Suite 10	JS, MIUIUUIIIAII, VA ZSII4 ● F	- 0U4-3/0-/2/3 F 8U	14-3/0-/20/		

Preapproved	Date	Name of Conference/ Course/ Event	Number of CEUs	
(please circle)	Date	Name of Comerence, Course, Event	Nulliber Of CEUS	
yes no				
yes no		Total CELIS:		

Total	CFUs		
IOIAL	L FLIS		