



# Certified Health Data Analyst (CHDA) Exam Application

Please submit this application with the appropriate fee to:  
Attn: CHDA Exam, AHIMA, Dept. 77-3081, Chicago, IL 60678-3081

*Type or print neatly. \* An asterisk indicates a required field*

- 1. AHIMA ID Number: \_\_\_\_\_
- 2.\* Social Security Number: \_\_\_\_\_ 3. Date of Birth: \_\_\_\_\_
- 4.\* First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_
- 5.\* Preferred Mailing Address:  Home  Work
- 6.\* Home Address: \_\_\_\_\_ Apt #/PO Box : \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_
- 7. Employer: \_\_\_\_\_  
Title: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Suite: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_
- 8. Work Phone: \_\_\_\_\_ 9.\* Home Phone: \_\_\_\_\_
- 10. Fax Number: \_\_\_\_\_ 11. E-mail Address: \_\_\_\_\_

**\*12. Eligibility (Indicate your eligibility for this examination)**

- Baccalaureate degree or higher and a minimum of five (5) years of healthcare data experience
- Healthcare Information Administration credential (RHIA) and a minimum of one (1) year of healthcare data experience

\*13. Experience will be verified by submitting a resume indicating experience working with healthcare data. In the space provided below, or by attaching a resume, please provide information substantiating your eligibility.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**14. Release of Passing Examination Results to Employer**

All individuals who successfully complete the examination are recognized for this achievement on the Newly Credentialed Professionals page of AHIMA’s web site. In addition, if authorized, a recognition letter will also be sent to your employer.

I authorize AHIMA to send a letter to my employer.

\*Supervisor’s Name: \_\_\_\_\_

\*Supervisor’s Title: \_\_\_\_\_

\*Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

\* 15. Will you require special accommodations for the administration of this examination?

No  Yes. (Complete Form A)

16. What is your highest educational degree? (*please select one*)

- (05)  Bachelor's Degree
- (06)  Master's Degree
- (07)  Doctoral Degree
- (08)  Doctor of Law (JD)
- (09)  Doctor of Medicine (MD)
- (99)  Other: \_\_\_\_\_

17. What is your current work setting? (*please select one*)

- (01)  Ambulatory Care Facility
- (02)  Behavioral/Mental Health Facility
- (03)  Consultant/Vendor
- (04)  Corporate Office of a Multi-Hospital System
- (05)  Educational Institution
- (06)  HIM Specialty Setting
- (07)  Home Health Agency
- (08)  Hospital
- (10)  Long Term Care Facility
- (11)  Managed Care/HMO/PPO Office
- (12)  Multi-Specialty Group Practice
- (13)  Non-Provider Organization
- (14)  Physician Office
- (98)  Currently Not Employed
- (99)  Other: \_\_\_\_\_

18. Who is covering the cost of this examination?

- (01)  Examinee
- (02)  Employer
- (03)  Both
- (04)  Other

19.\* What is your current job level category? (*please select one*)

- (01)  Executive/president/Vice President
- (02)  Director
- (03)  Educator
- (04)  manager/Supervisor
- (05)  Consultant
- (06)  Clinical (MD, RN, etc.)
- (07)  Technology Professional (including data or systems analyst)
- (08)  HIM Technician
- (09)  Clerical/Administrative Support
- (99)  Not Currently Working

**\*Examination Fees**

AHIMA member fee:.....\$259

Nonmember fee:..... \$329

**Indicate Method of Payment**

Check/Money Order – Payable to AHIMA

Purchase Order:  Attached  To come: # \_\_\_\_\_

Credit Card:  VISA       MasterCard       American Express

*If payment is by credit card, please provide the following information.*

Account #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Statement of Understanding**

I hereby apply to write the CHDA examination. I have read and fully understand the information posted on [www.ahima.org/certification](http://www.ahima.org/certification). I have reviewed and agree to abide by the AHIMA Code of Ethics. I certify that the information provided on this application (and any subsequent forms submitted in relation to this application) is accurate. I understand that falsification in this document will be grounds for rejection of my application, revocation of any certification issued, or denial of recertification.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_