

Examination Application

■ Certified in Healthcare Privacy and Security (CHPS) ■ Certified Health Data Analyst (CHDA)

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

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

- * 1. Examination Type: CHPS
2. AHIMA ID Number (if applicable): _____ *3. Last 4 digits of your Social Security Number: _____
4. Date of Birth: _____
- * 5. First Name: _____ MI: ____ Last Name: _____ Suffix: _____
- * 6. Preferred Mailing Address: Home or Work
- * 7. Home Address: _____ Apt. #/PO Box: _____
City: _____ State: _____ Zip Code: _____ Country: _____
8. Employer: _____
Title: _____
Work Address: _____ Suite: _____
City: _____ State: _____ Zip Code: _____ Country: _____
9. Work Phone: _____ *10. Home Phone: _____
11. Fax Number: _____ 12. E-mail Address: _____

AHIMA Credential History

- * 13. Have you taken this examination before?
 Yes Month and Year: _____
 No
- * 14. Have you ever had an AHIMA credential revoked?
 Yes Credential and Date: _____
 No

CHPS Eligibility

- * 15. Eligibility (Indicate your eligibility for this examination)
(600) Baccalaureate degree and a minimum of four (4) years of experience in healthcare management
(602) Master's or related degree (JD, MD, PhD) and two (2) years of experience in healthcare management
(603) Healthcare information management credential (RHIT, RHIA) with a baccalaureate or higher degree and a minimum of two (2) years of on-the-job experience in healthcare management
- * 16. Eligibility in healthcare management requires a resumé of managing people and/or projects in healthcare organizations. Please provide information substantiating your eligibility in the space provided below, or attach a current resumé.

CHDA Eligibility

- * 17. Eligibility (Indicate your eligibility for this examination)
(700) Baccalaureate degree or higher and a minimum of five (5) years of healthcare data experience
(701) Healthcare Information Administration credential (RHIA and a minimum of one (1) year of healthcare data experience
- * 18. Experience will be verified by submitting a resumé indicating experience working with healthcare data. Please provide information substantiating your eligibility in the space provided below, or attach a current resumé.

I certify that the eligibility information provided by me is accurate and attest that I meet the eligibility criteria for the _____ exam. I understand that all _____ certifications awarded are subject to audit in order to verify candidate eligibility. If my application is selected as a result of the audit process, I will be required to submit documentation to support the eligibility information in my application. I further understand that if any information is later determined to be false, The Commission on Certification for Health Informatics and Information Management (CCHIIM) can reject my application and not allow me to take the examination; invalidate the results of my examination; and revoke any certification issued.

Education and Experience

- * 19. What is your highest educational degree? *(please select one)*
 - (01) High School Graduate
 - (02) HIM Certificate Program
 - (03) AHIMA ISP Program
 - (04) Associate Degree
 - (05) Baccalaureate Degree
 - (06) Master's Degree
 - (07) Doctorate
 - (08) Doctor of Law (JD)
 - (09) Doctor of Medicine (MD)
 - (99) Other _____

- * 20. How many years of healthcare management experience do you have?
 - (01) 1–5 years
 - (02) 6–9 years
 - (03) 10–13 years
 - (04) 14–17 years
 - (05) Over 17 years

- 21. 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's Office
 - (98) Currently Not Employed
 - (99) Other: _____

- 22. What is your current job level category? *(please select one)*
 - (01) Executive/President/Vice President
 - (02) Director (HIM, IT, etc.)/Officer (for example, privacy, security, compliance)
 - (03) Educator
 - (04) Manager/Supervisor
 - (05) Consultant
 - (06) Clinical (MD, RN)
 - (07) Technology Professional (including data or systems analyst)
 - (08) HIM Technician (for example, coding, transcription)
 - (09) Clerical/Administrative Support
 - (99) Not currently working

- 23. Who is covering the cost of this examination?
 - (01) Examinee (02) Employer
 - (03) Both

- 24. Have you primarily obtained privacy and security training? *(please select one)*
 - (00) None
 - (01) On the Job Experience
 - (02) Seminars/Workshops
 - (03) University Programs
 - (99) Other: _____

- 25. Which of the following credentials do you currently hold?
 - (01) CCA (02) CCS (03) CCS-P
 - (04) CHP® (05) CHS (06) CHPS
 - (07) CPC (08) CPC/H (09) CPHIMS
 - (10) RHIA (11) RHIT (12) RN
 - (13) CHDA (99) Other: _____

Americans with Disabilities Act (ADA)

- * 26. Will you require special accommodations for the administration of this examination?
 - Yes (Complete Forms A and B)
 - No

Release of Examination Results

- * 27A. **AHIMA's Web Site** – all candidates who successfully pass the examination are recognized for this achievement on AHIMA's web site.
 - I authorize the release of my name to be posted on AHIMA's web site.
- 27B. **School Reports** – all examination scores are reported to the appropriate AHIMA approved coding program. Your name will be reported with your scores if you authorize the release of your name.
 - I authorize the release of my name to my academic program (CCA only)
- 27C. **Employer Letter** – AHIMA will send a recognition letter to your employer if you successfully pass the examination (A letter will not be sent for unsuccessful candidates)
 - I authorize AHIMA to send a letter to my employer.

Supervisor's Name: _____
Supervisor's Title: _____
Company: _____
Address: _____
City: _____
State: _____ Postal Code: _____
Country: _____

2009 Examination Fees

- AHIMA member fee: \$259
- Nonmember fee: \$329

Method of Payment

- Check/Money Order: *Payable to AHIMA*
- Credit Card:
 - Visa MasterCard American Express
- Account #: _____
- Exp. Date: _____
- Signature: _____

How did you find out about the CHPS/CHDA certification?

Statement of Understanding

I hereby apply to write the CHPS/CHDA examination. I have read and fully understand the Certification Candidate Guide and all sections therein, as well as the AHIMA Code of Ethics. I agree to abide by the terms of the Certification Candidate Guide and the AHIMA Code of Ethics, as well as any other requirements set forth in this application. I certify that the information provided by me on this application (and any subsequent forms submitted in relation to this application) is accurate. I understand that the submission of false information in this or any other document will be grounds for rejection of my application, revocation of any certification issued, or denial of recertification, at the sole discretion of AHIMA.

Signature: _____ Date: _____

Form A—Request for Accommodations under the Americans with Disabilities Act (ADA)

1. First Name: _____ MI: _____ Last Name: _____

2. Address: _____

City: _____ State: _____ Zip Code: _____

Country: _____

3. For which of the following exams are you requesting accommodations?

CCA CCS CCS-P RHIA RHIT CHPS CHDA

4. Nature of your disability:

Hearing Learning
 Visual Psychiatric
 Physical Other, please specify _____

5. How long ago was your disability diagnosed?

Less than 1 year 2–5 years
 1–2 years Over 5 years

6. In order to fully document your need for accommodations, please include a brief personal statement describing your disability and its impact on your daily life and educational functioning.

7. Have you previously received accommodations in any educational or testing situation?

Yes No

If yes, please describe the accommodations received.

8. Which of the following accommodations are you requesting?

Separate testing room Reader
 Extended testing time Other, please specify _____
 Screen magnifier/zoom technology

I certify that the information provided above is true and accurate.

Signature: _____ Date: _____

Form B—Documentation of Disability-Related Needs

To the Professional:

By submitting this form with your signature and license number, you are verifying that you have formally diagnosed the candidate named on this form as having the disability documented below or, in a professional capacity, have worked with the candidate in dealing with the documented disability. You further verify that the accommodation you recommend is necessary to fairly demonstrate the candidate’s ability on the examination.

The intent is to provide equal opportunity for all candidates. The accommodation must not unfairly advantage or disadvantage the candidate.

I have known _____ since (date) _____

in my capacity as a _____.

Please include the following:

- Diagnosis (note: mental and emotional disabilities must include a diagnosis code from the DSM-IV)
- Description of the candidate’s disability and how the disability affects the candidate’s major life activities (for example, hearing, seeing, walking, talking, performing manual tasks).
- Recommended accommodations

Signature: _____ Date: _____

Title: _____ License number: _____