

Examination Application

- **Certified Coding Associate (CCA)**
- **Certified Coding Specialist (CCS)**
- **Certified Coding Specialist—Physician-based (CCS-P)**

Please submit this application with the appropriate fee to:
Attn: Coding Exams, AHIMA, Dept. 77-3081, Chicago, IL 60678-3081
Type or print neatly. An asterisk () indicates a required field*

- * 1. Examination Type: CCA CCS CCS-P
2. AHIMA ID Number: _____ *3. Date of Birth: _____
- * 4. First Name: _____ MI: ____ Last Name: _____ Suffix: _____
- * 5. Preferred Mailing Address: Home or 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: _____ 11. E-mail: _____

AHIMA Credential History

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

Eligibility

- * 14. Indicate your eligibility for this examination
(605) US high school diploma or equivalent

Education and Experience

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

**An asterisk indicates a required field.*

Education and Experience

- * 16. 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: _____
17. Who is covering the cost of this examination?
- (01) Examinee (02) Employer
 - (03) Both
- * 18. If you indicated "AHIMA-Approved Coding Certificate Program" on Question #16, indicate your program's Education Program Code (EPC):
- _____
19. 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)

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

Release of Examination Results

- * 21A. **AHIMA's Website**—All candidates who successfully pass the examination are recognized for this achievement on AHIMA's website.
- I authorize the release of my name to be posted on AHIMA's website.
- 21B. **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)
- 21C. **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: _____ Zip Code: _____

Country: _____

Examination Fees

- CCA Member \$199
- CCA Nonmember \$299
- CCS AHIMA Member \$299
- CCS Nonmember \$399
- CCS-P AHIMA Member \$299
- CCS-P Nonmember \$399

Method of Payment (Source Code: RMAIL)

- Check/Money Order: Payable to AHIMA

Credit Card:

- Visa MasterCard American Express Discover

Account #: _____

Exp. Date: _____

Signature: _____

How did you find out about CCA, CCS, and/or CCS certification?

Statement of Understanding

I hereby apply to write the CCA, CCS, or CCS-P 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, and 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: _____

**Certified Coding Associate (CCA), Certified Coding Specialist (CCS),
Certified Coding Specialist—Physician-based (CCS-P)**

AHIMA
American Health Information
Management Association®

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 CDIP

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: _____