

# Examination Application

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

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:  CHPS  CHDA
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 Number: \_\_\_\_\_ 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

### CHPS New Eligibility

- \* 14. Eligibility (Indicate your eligibility for this examination)
- (700)  Associate's degree and six (6) years experience in healthcare privacy or security management
- (701)  Healthcare information management credential (RHIT) and minimum of four (4) years of experience in healthcare privacy or security management
- (702)  Baccalaureate degree and a minimum of four (4) years experience in healthcare privacy or security management
- (703)  Healthcare information management credential (RHIA) and minimum of two (2) years of experience in healthcare privacy or security management
- (704)  Master's or related degree (JD, MD, or PhD) and two (2) years of experience in healthcare privacy or security management

### CHDA New Eligibility

- \* 15. Eligibility (Indicate your eligibility for this examination)
- (600)  Associate's degree and minimum of five (5) years of healthcare data experience
- (601)  Healthcare information management credential (RHIT) and minimum of three (3) years of healthcare data experience
- (602)  Baccalaureate degree and a minimum of three (3) years of healthcare data experience
- (603)  Healthcare information management credential (RHIA) and minimum of one (1) year of healthcare data experience
- (604)  Master's or related degree (JD, MD, or PhD) and one (1) year of healthcare data experience

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 (CCHIM) can reject my application and not allow me to take the examination; invalidate the results of my examination; and revoke any certification issued.

\*An asterisk indicates a required field.

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**Education and Experience**

- \* 16. 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
17. 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
\* 18. 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 (09) Long-Term Care Facility (10) Managed Care/HMO/PPO Office (11) Multi-Specialty Group Practice (12) Non-Provider Organization (13) Physician's Office (14) Currently Not Employed (98) Currently Not Employed (99) Other
19. Who is covering the cost of this examination? (01) Examinee (02) Employer (03) Both
20. 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

- 21. 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)**

- \* 22. Will you require special accommodations for the administration of this examination? Yes (Complete Forms A and B) No

**Release of Examination Results**

- \* 23A. 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.
23B. 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:

**2012 Examination Fees**

- AHIMA Member fee \$259 Nonmember fee \$329

**Method of Payment**

- Check/Money Order: Payable to AHIMA Credit Card: Visa MasterCard American Express Discover 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: