

Examination Application

■ Registered Health Information Administrator (RHIA) ■ Registered Health Information Technician (RHIT)

Please submit this application with the appropriate fee to:

Attn: RHIA/RHIT Exams, AHIMA, Dept. 77-3081, Chicago, IL 60678-3081

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

- * 1. Examination Type: RHIA RHIT
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 Address: _____

Eligibility

- * 12. Indicate your eligibility for this examination.
- (001) Graduate of an HIA—
CAHIIM-accredited program
- (002) Graduate of an HIT—
CAHIIM-accredited program
- (998) Graduate of a formerly accredited
program
- (510) An HIT certificate of completion
from AHIMA's ISP and an associate's
degree from an accredited college.

School Name: _____

* Educational Program Code (EPC): _____

* Graduation Date (MM/DD/YY): _____

Have you ever taken this exam before?

- Yes Month _____ Year _____
- No
- Transcript enclosed with application
- Transcript will be sent separately

Americans with Disabilities Act (ADA)

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

Employer Notification

- *14. All individuals who successfully pass the examination are recognized for this achievement on AHIMA's Web site or in the *Journal of AHIMA*. In addition, if authorized, a recognition letter will be sent to your employer.

I authorize AHIMA to send a letter to my employer.

Supervisor's Name: _____

Supervisor's Title: _____

Company: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Country: _____

Recognition on AHIMA's Web site

- * 15. All candidates who successfully pass the examination are recognized for this achievement on AHIMA's Web site.
- I do not authorize AHIMA to post my name on AHIMA's Web site.

Release of Examination Results

- * 16. All examination scores are reported to the appropriate CAHIIM-accredited educational program. Your name will be reported with your score. Candidate score information helps HIM programs maintain CAHIIM's high standards of educational excellence. Program directors use this data to continuously improve upon their curriculum and student learning. If you prefer your name and results NOT be released to your program director, please check the box below.
- I do not authorize the release of my name to my academic program (RHIA and RHIT only).

**An asterisk indicates a required field.*

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Education and Experience

- * 17. What is your highest educational degree?
Please select one.
- (04) Associate Degree
- (05) Baccalaureate Degree
- (06) Master's Degree
- (07) Doctorate
- (08) Doctor of Law (JD)
- (09) Doctor of Medicine (MD)
- (99) Other _____

- * 18. What is your current work setting? *(Please select one.)*
- (01) Ambulatory Care
- (02) Behavioral/Mental Health
- (03) Consulting/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 Practice
- (98) Currently Not Employed
- (99) Other: _____

- 19. 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, etc)
- (07) Technology Professional (including data or systems analyst)
- (08) HIM Technician (e.g. coding, transcription)
- (09) Clerical/Administrative Support
- (99) Not currently working

- 20. How many years of HIM experience do you have?
- Less than 1 year 1-4 years
- 5-10 years 11-19 years
- 20-29 years 30+ years
- Not applicable

- 21. Who is covering the cost of this examination?
- (01) Examinee (02) Employer
- (03) Both
- 22. 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: _____

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

2011 Examination Fees

- RHIA Member \$229
- RHIA Nonmember \$299
- RHIT Member \$229
- RHIT Nonmember \$299

Method of Payment (Source Code: RMAIL)

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

Account #: _____
 Exp. Date: _____
 Signature: _____

How did you find out about the RHIA/RHIT certification?

Statement of Understanding

I hereby apply to write the RHIA or RHIT 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: _____

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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: _____