

AHIMA Ambassador Program Enrollment Form

Please complete the following form and return the form via e-mail to thomas.duffy@ahima.org or fax it 312.233.1460

AHIMA ID Number: _____

Ambassador Information:

First Name: _____ MI: _____ Last Name: _____

Personal Webpage (URL): _____

City: _____ State: _____

E-mail Address: _____

Setting/Specialty Information:

Please fill in settings/specialty area that you have experience in and would be willing to provide training for – please check all that apply

Acute care _____ Long-term care _____ Home health _____ Rehabilitation facility _____

Behavioral Health _____ Public health entity (local and state) _____

Outpatient facility/Clinic _____ Physician Practice _____

Please identify medical specialty(s): _____

Educational Category (please check all that apply):

Coding Professional Education _____ General Overview/Awareness Education _____

Implementation Preparation _____ Mapping _____

Clinical Documentation Impact/Preparation _____