Examination Application – **Outside the US**

Certified Docum ent Improvem ent Practitioner (CDIP)

Please submit this application with the appropriate fee to:

AHIMA
233 N. Michigan Ave., 21st Floor
Chicago, IL 60601
ATTN: CDIP outside the U.S. Exam Application
Fax: 312-233-1500

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

1. AHIMA ID Number: ______________________ * 2. Date of Birth: ______________

* 3. First Name: ______________MI: _____Last Name: ____________________Suffix: ______

* 4. Preferred Mailing Address: ☐Home or ☐Work

* 5. Home Address: ______________________________Apt. #/PO Box: ________

City: ______________State: _____Zip Code: __________Country:__________

6. Employer:

Title: ____

Work Address: ______________________________ Suite:

City: ______________State: _____Zip Code: __________Country:__________

7. Work Phone: ______________________ * 8. Home Phone: ______________________

9. Fax: ______________________ 10. E-mail: ______________________

Eligibility

* 11. Have you taken this examination before?

☐ Yes ☐ No

Credential and Date: ______________________

*12. Have you ever had an AHIMA credential revoked?

☐ Yes ☐ No

Credential and Date: ______________________

Eligibility

*13. Indicate your eligibility for this exam.

☐ An RHIA, RHIT, CCS, CCS-P, RN, MD, DO, PA and two (2) years experience in clinical documentation improvement.

☐ An Associate's degree or higher and three (3) years of experience in clinical documentation improvement (candidates must also have completed coursework in medical terminology and anatomy and physiology)

Experience will be verified through an audit process of candidates' resumes. Upon audit, resumes must indicate experience in clinical documentation improvement.

Please provide some brief information substantiating your eligibility in the space below.

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Education and Experience

*14. What is your current work setting?

(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: ______________________

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

16. 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)

* 17. Will you require special accommodations for the administration of this examination?

☐ Yes (Complete Part 1 and 2)

☐ No

Release of Examination Results

* 18. All individuals who successfully pass the exam are recognized for this achievement on the Newly Credentialed Professionals page of AHIMA's website. A recognition letter will also be sent to your employer,

☐ I authorize AHIMA to post my name on the AHIMA website.

☐ I authorize AHIMA to send a letter to my employer.

Supervisor's Name: ____________________

Supervisor's Title: ____________________

Company: ____________________

Address: ____________________

City: ____________________

State: ____________ Postal Code: ____________

Country: ____________________

19. Will you require special accommodations for the administration of this examination?

☐ No ☐ Yes (If yes, complete Part 1 and 2)

Eligibility Attestation

20. I certify that the eligibility information provided by me is accurate and attest that I meet the eligibility criteria for the CDIP exam. I understand that all certifications awarded are subject to audit in order to verify candidate eligibility. If my application is selected 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 exam; invalidate the results of my exam and revoke any certification issued.

Signature: ____________________

Date: ____________________

Examination Fees

☐ AHIMA Member $259

☐ AHIMA Nonmember $329

Method of Payment

☐ Check/Money Order: Payable to AHIMA

Credit Card:

☐ Visa

☐ Mastercard

☐ American Express

☐ Discover

Account #: ____________________

CVV: ________ Expiration Date: ____________

Card Holder Name: ____________________

Card Holder Address: ____________________

Signature: ____________________

How did you find out about the CDIP certification?

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Statement of Understanding

I hereby apply to write the CDIP 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 other 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: ____________

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Submitting your Application - Three (3) options:

1. By E-mail:

Please scan your completed application and send to: certification@ahima.org

OR

2. By Mail:

AHIMA
233 North Michigan Ave., 21st Floor
Chicago, IL 60601-5800
ATTN: CDIP Outside the US Exam Application

OR

3. By Fax: (312) 233-1500