Examination Application – Outside the US

Certified Health Data Analyst (CHDA)

Please submit this application with the appropriate fee to:

AHIMA
233 N. Michigan Ave., 21st Floor
Chicago, IL 60601
ATTN: CHDA 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.
   □ Healthcare information management credential (RHIT*) and minimum of three (3) years of healthcare data experience
   □ Baccalaureate degree and a minimum of three (3) years of healthcare data experience
   □ Healthcare information management credential (RHIA*)
   □ Master’s in Health Information Management (HIM) or Health Informatics from an accredited school
   □ Master’s or higher degree and one (1) year of healthcare data experience

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.

_____________________________________________________________________________

_____________________________________________________________________________

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: ___________________________
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) CHF  (05) CHS  (06) CHPS  
(07) CPC  (08) CPC/l  (09) CPHIM  (10) RHIL  (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 CHDA 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 (CCHIM) 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**  
☐ $259  
☐ $329

**Method of Payment**  
☐ Check/Money Order: Payable to AHIMA

  Credit Card:  
  ☐ Visa  
  ☐ Mastercard  
  ☐ American Express  
  ☐ Discover  
  Account #: ____________________________  
  CVV: ____________________________  
  Exp. Date: ____________________________  
  Card Holder Name: ____________________________  
  Card Holder Address: ____________________________

  Signature: ____________________________

**Statement of Understanding**  
I hereby apply to write the 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 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: ____________________________

**Certified Health Data Analyst (CHDA)**

MX9994
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: CHDA Outside the US Exam Application

   OR

3. **By Fax:** (312) 233-1500