# Examination Application

Please submit this application with the appropriate fee to:

AHIMA, Attn: CPHI Exam Application
233 N. Michigan Ave., 21st Floor
Chicago, IL 60601

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: _______

6. Employer: _______________________________________________________________________________
   Title: ___________________________________________________________________________________

   Work Address: _____________________________________________________ Suite: ________________

7. Work Phone: ______________________________  * 8. Home Phone:  _____________________________

9. Fax: ______________________________  10. E-mail: ___________________________________________

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### 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. Candidates must meet one of the following eligibility requirements for the Health Informatics examination
   - Baccalaureate degree and two (2) years of health informatics experience**
   - Master’s degree or higher and one (1) year of health informatics experience**
   - Master’s degree in health informatics from an accredited health informatics program

** Candidates are responsible for ensuring their eligibility to sit for the exam. Candidates must formally attest to the required experience in health informatics.

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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: ______________________________
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 CPHI 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
☐ Premiere Member Rate: $246
☐ Member Rate: $259
☐ Non-Member: $311

Method of Payment
☐ Check/Money Order: Payable to AHIMA
☐ Visa ☐ MasterCard
☐ American Express ☐ Discover
Account Number: ____________________________
Expiration Date: __________ CVV: ___________
Credit Card Holder’s Name: ____________________
Credit Card Holder’s Address: __________________
Company: ____________________________________
Address: ____________________________________
State: ___________________ Postal Code: __________
Country: ____________________________________

Signature: ____________________________ Date: ______________________

note that the name and address fields are case sensitive

AHIMA Exam Application Checklist
21. Candidates must ensure that all items on this checklist are completed in order for their exam to be processed:
   ☐ Read the Candidate Guide
   ☐ Make sure the first and last name provided on the application matches the name on the primary identification
   ☐ Confirm meeting eligibility criteria
   ☐ Include payment (credit card, check, money order)
   ☐ Complete special accommodations form (Americans with Disabilities Act), if applicable
   ☐ Sign Statement of Understanding

How did you find out about the CPHI certification?
_____________________________________________________________________________________________________

Statement of Understanding
I hereby apply to write the CPHI 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 Professional in Health Informatics (CPHI)