Application for Early Testing

PART 1 (to be completed by exam candidate)

EXAM CANDIDATE

Name: __________________________   __________________________   __________________________

                    (First)                     (Middle)                     (Last)

RHIA ______  RHIT ______

AHIMA ID Number (if applicable): __________________________

Preferred Mailing Address: ______________________________________

               (Street Address)       (City)

               (State)               (Zip)               (Country)

Work Phone: __________________________   Home Phone: __________________________

I hereby apply for early testing and will fulfill all the requirements for early testing as stated in the FAQs located at www.ahima.org/certification. The information contained in Part 1 of this application is accurate and complete as of the date that I sign. Furthermore, I understand that in order to obtain my credential, I must send in a paper exam application with this form, pass the RHIA/RHIT exam, complete all coursework in my respective Commission of Health Informatics and Information Management Education (CAHIIM) accredited program and send in a completed school transcripts to the membership department of AHIMA. Failure to meet one of these requirements will result in an incomplete application and AHIMA will not issue an official certificate or acknowledge my right to use this credential.

I have read and understand the contents of this application __________________________   __________________________

(Candidate Signature)   (Date)

PART 2 (to be completed by program director)

PROGRAM DIRECTOR

Type of Program:   HIA ☐   HIT ☐

Program Director: __________________________   __________________________   __________________________

                    (First)                     (Middle)                     (Last)

School: ______________________________________   EPC (Educational Program Code): ____________

School Mailing Address: ______________________________________

                (Street Address)       (City)

                (State)               (Zip)               (Country)

Work Phone: __________________________   E-mail: __________________________

I am the current program director of the aforementioned school and verify that all of the information contained in Part 1 and Part 2 of this application is current and accurate. Furthermore, I verify that this candidate is in his/her last term of learning and is eligible to register to apply for his exam under the FAQs found at www.ahima.org/certification.

_____________________________   __________________________

(Program Director Signature)   (Date)
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: ____________

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.
Education and Experience

17. What is your highest educational degree?

- [ ] Associate Degree
- [ ] Baccalaureate Degree
- [ ] Master’s Degree
- [ ] Doctorate
- [ ] Doctor of Law (JD)
- [ ] Doctor of Medicine (MD)
- [ ] Other: ________________________________

18. What is your current work setting? (Please select one.)

- [ ] Ambulatory Care
- [ ] Behavioral/Mental Health
- [ ] Consulting/Vendor
- [ ] Corporate Office of a Multi-Hospital System
- [ ] Educational Institution
- [ ] Home Health Agency
- [ ] Hospital
- [ ] Long-term Care Facility
- [ ] Managed Care/HMO/PPO Office
- [ ] Multi-Specialty Group Practice
- [ ] Non-Provider Organization
- [ ] Physician Practice
- [ ] Currently Not Employed
- [ ] Other: ________________________________

19. What is your current job level category? (Please select one.)

- [ ] Executive/President/Vice President
- [ ] Director (HIM, IT, etc.)/Officer (for example, privacy, security, compliance)
- [ ] Educator
- [ ] Manager/Supervisor
- [ ] Consultant
- [ ] Clinical (MD, RN, etc)
- [ ] Technology Professional (including data or systems analyst)
- [ ] HIM Technician (e.g. coding, transcription)
- [ ] Clerical/Administrative Support
- [ ] 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?

- [ ] Examinee
- [ ] Employer
- [ ] Both

22. Which of the following credentials do you currently hold?

- [ ] CCA
- [ ] CCS
- [ ] CCS-P
- [ ] CHP
- [ ] CHS
- [ ] CHPS
- [ ] CPC
- [ ] CPC/H
- [ ] CPHIMS
- [ ] RHIA
- [ ] RHT
- [ ] RN
- [ ] CHDA
- [ ] 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
- [ ] 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: ________________________________

Registered Health Information Administrator (RHIA)
Registered Health Information Technician (RHIT)
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: __________________________

MX5968
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: _________________________