Examination Application

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

Type or print clearly. 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: __________


7. Employer: _______________________________________________________________________________

Title: ________________________________________________________________

Work Address: _____________________________________________________ Suite: ________________


8. Work Phone: ______________________________  * 9. Home Phone:  _____________________________

10. Fax: ______________________________  11. E-mail: ____________________________________________

Eligibility

* 12. Indicate your eligibility for this examination.
   (001)  □ Graduate of HIA—CAHIIM-accredited program
   (002)  □ Healthcare information management
   Graduate of 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/D/YY): _____________________

* 13. Have you taken this examination before?
   □ Yes   □ No
   Month: ______ Year: ____________

   □ Transcript enclosed with application
   □ Transcript will be sent separately

Americans with Disabilities Act (ADA)

* 14. Will you require special accommodations for the administration of this examination?
   □ Yes (Complete Part 1 and 2)   □ No

Employer Notification

* 15. If you successfully pass the examination a recognition letter will be sent to your employer. (No letter will be sent for unsuccessful candidates.)
   □ I authorize AHIMA to send a letter to my employer.
   Supervisor’s Name: _____________________________
   Supervisor’s Title: ______________________________
   Company: ____________________________________
   Address: _____________________________________
   City: _________________________________________
   State: _________________ Postal Code: ____________
   Country: ______________________________________

Recognition on AHIMA’s Website

* 16. All candidates who successfully pass the examination are recognized for this achievement on AHIMA’s website.
   □ I do not authorize the release of my name to be posted on AHIMA’s website.

Please submit this application with the appropriate fee to:
Attn: Coding Exams, AHIMA
Dept. 77-3081
Chicago, IL 60678-3081

If you submit transcripts separately, please send them to:
Certification Transcripts
233 N. Michigan Ave, 21st Floor
Chicago, IL 60601

Registerd Health Information Administrator (RHIA)
Registered Health Information Technician (RHIT)

AHIMA
American Health Information Management Association®

MX9994

MX9994_RHIA_RHIT_ExamApp.indd   1
10/10/14   4:02 PM
Release of Examination Results
*T 17. All examination scores are reported to the appropriate CAHIIM-accredited educational program. Your name will be reported with your score. Candidate score information helps CAHIIM-approved HIM programs maintain high standards of educational excellence. Program directors use this data to continuously improve upon their curriculum and student learning.
☐ I do not authorize the release of my name to be posted on AHIMA’s website.

Education and Experience
*T 18. What is your highest educational degree? Please select one:
   (04) ☐ Associate’s Degree
   (05) ☐ Baccalaureate Degree
   (06) ☐ Master’s Degree
   (07) ☐ Doctorate
   (08) ☐ Doctor of Law (JD)
   (09) ☐ Doctor of Medicine (MD)
   (10) ☐ AHIMA Approved Coding Program
   (99) ☐ Other: ________________________________

*T 19. What is your current work setting? (Please select one.)
   (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
   (09) ☐ Long-term Care Facility
   (10) ☐ Managed Care/HMO/PPO Office
   (11) ☐ Multi-Specialty Group Practice
   (12) ☐ Non-Provider Organization
   (13) ☐ Physician’s Office
   (98) ☐ Currently Not Employed
   (99) ☐ Other: ________________________________

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

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

22. 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: ________________________________

Examination Fees
☐ RHIA Member $229
☐ RHIA Nonmember $299
☐ RHIT Member $229
☐ RHIT Nonmember $299

Method of Payment
☐ Check/Money Order: Payable to AHIMA
☐ Credit Card:
   ☐ Visa
   ☐ Mastercard
   ☐ American Express
   ☐ Discover
   Account Number: ________________________________
   Expiration Date: ________________________________
   Signature: ____________________________________

Statement of Understanding
I hereby apply to write the RHIA/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 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: ____________________

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