



2016 CCDS Re-Exam Application

Certified Clinical Documentation Specialist (CCDS)

Please submit this application with the appropriate fee to:

Penny Richards
CCDS Program
35 Village Road, Suite 200
Middletown, MA 01949

This is an online application that you can fill in, save, and email to ccdsapp@acdis.org. Save your file in the following format, using your first initial and last name (see example below)

CCDS_REEXAM_PRICHARDS

Fax 978/560-0934
Attn: Penny Richards

I. Personal information

Name: _____ Credentials: _____ Job Title: _____
 Home Address: _____ Home Phone: _____
 City/State/Zip: _____ Cell: _____
 Company Name: _____ Work Phone: _____
 Company Address: _____
 Company Address 2: _____ Work Fax: _____
 City/State/Zip: _____
 E-mail: _____

ACDIS member: Yes No

(*Your certificate will be mailed to your home address. Your home address will not be used for marketing or commercial purposes..)

2. Educational background

High School/GED Equivalent: _____ City/State: _____ Degree: _____
 College or University (last attended): _____ City/State: _____ Degree: _____
 Additional college-level courses taken: _____

3. Work experience

(please update if work address has changed since your previous application)

Current facility/company name: _____
 Dates of employment (Starting month/year to current): _____
 Immediate supervisor's name: _____
 Supervisor's phone number: _____
 Supervisor's e-mail address: _____

Add additional work experience if in current position less time than required to meet CCDS Exam eligibility requirements.

Previous facility/company name: _____
 Dates of employment (Starting month/year to ending month/year): _____

RE-EXAM



4. Current certifications

Please check which of the following certifications you currently hold

ACM	BS	BSN	CCM	CCS	CIC	CLNC
CMAC	CPC-H	CPHQ	CPUR	CTR	FNP	LPN
MBA	MD	MPH	MS	MSN	RHIA	RHIT
RN	Other, please specify: _____					

5. Release of examination results

ACDIS recognizes the achievement of all individuals who successfully complete the CCDS examination on the **ACDIS** web site and/or in the *CDI Journal*. May we use your name in these publications? Yes No

6. Method of payment

Click this link to pay online, then fax or scan/email your application according to the instructions on the application. If you prefer you may pay by check and mail with the application.

7. Location of Exam

You will receive an email with instructions to schedule your exam at the AMP Testing Center of your choice.

8. Americans with Disabilities Act

Will you require special accommodations for the administration of this examination? Yes No
(If yes, complete the 2-page *Request for Special Examination Accommodations* form and submit with this application.)

9. Code of ethics

I hereby attest that the above information is true and accurate. I have read and fully understand the candidate handbook and all sections therein, as well as the **ACDIS** Code of Ethics. I agree to abide by the terms of the candidate handbook and the **ACDIS** Code of Ethics, as well as any other requirements set forth in this application.

I certify that I have fulfilled one of the four required routes to take the exam and that the information provided by me on this application is accurate.

I understand that the submission of false information will be grounds for rejection of my application at the sole discretion of **ACDIS**. I understand that some applications may be audited for accuracy.

Signature: _____

Date: _____