Association of Clinical Documentation Improvement Specialists

2017 CCDS Re-Exam Application

Certified Clinical Documentation Specialist (CCDS)

This is an editable PDF. Download it to your desktop, fill it out, save it and email, fax or US mail.

Attn: HCPro
Penny Richards
Certified Clinical Documentation Specialist Program
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Middleton, MA 01949

Fax 978/560-0934
Attn: Penny Richards
E-mail *prichards@hcpro.com*

Type or print neatly.

1. Personal information

Name: _____ Title: _____ Suffix: _____

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): _____

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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

Fax or scan/email your application according to the instructions on the first page. Then click this link to pay online. If you are an ACDIS member, log into your ACDIS membership and go to hcmarketplace.com/ccds-certification to pay the member price. If you prefer you may mail a check 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 thi 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: _____

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