



2018 CCDS Recertification Application

Personal information

CCDS ID Number: _____
Name: _____
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

Please check the mailing address that you would prefer to receive CCDS correspondence:

Home Work

Method of payment—Credential maintenance fee

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.

Attestation Statement

I verify the truth of the information submitted on this Continuing Education Submission Form. I affirm that I participated in continuing education activities and that the number of units reported is correct. If audited, I will supply supporting documentation verifying participation and summarizing content for all CEUs.

Signature: _____ Date: _____

Submit to: HCP
Penny Richards
Certified Clinical Documentation Specialist Program
35 Village Road, Suite 200
Middleton, MA 01949

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