Examination Application

Certified Clinical Documentation Specialist Outpatient (CCDS-O)

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

Attn: HCPro
CCDS-O Program
Penny Richards
35 Village Road, Suite 200
Middleton, MA 01949

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

Type or print neatly.

1. 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

(Home address required as your certificate will be mailed to your home address. It 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

Current facility/company name: ____________________

Dates of employment (Starting month/year to current): ____________________

Length of time as an Outpatient CDI Specialist: ____________________

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-O Exam eligibility requirements. Previous facility/company name: ____________________

Dates of employment (Starting month/year to ending month/year): ____________________

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Name: ______________________________

4. Current certifications

Please check which of the following certifications you currently hold.

ACM	CCM	CMAC	CRC	MBA	MSN
BS	CCS	CPC	CTR	MD	RHIA
BSN	CIC	CPHQ	FNP	MPH	RHIT
CCDS	CLNC	CPUR	LPN	MS	RN

Other, please specify: ______________________________

5. Release of examination results

ACDIS recognizes the achievement of all individuals who successfully complete the 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. If you are an ACDIS member, log into your ACDIS membership and go to *hcmarketplace.com* 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 PSI 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 the requirements 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: ______________________________

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