

FORM A - HCQM Certification Exam Order Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

Name: _____ Degree: _____
PLEASE PRINT OR TYPE

Title: _____ Employer: _____

Business Address: _____

City: _____ State: _____ Zip: _____ Work Phone: (____) _____

Fax: (____) _____ E-Mail: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: (____) _____

Fax: (____) _____ E-Mail: _____

How did you hear about ABQAURP? _____

	AIHQ Member	Non-Member
Core Body of Knowledge (CBK) Course		
Online (must pay and complete online - 60 day limit)	<input type="checkbox"/> \$245.00	<input type="checkbox"/> \$295.00
Certification Exam		
Exam Application Fee (non-refundable)*	<input type="checkbox"/> \$125.00	<input type="checkbox"/> \$150.00
HCQM Certification Exam Fee**	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$475.00

* The application in this packet must be completed and returned with the non-refundable application fee for verification of eligibility.

** The certification exam fee is non-refundable, unless the candidate is determined ineligible to sit for the exam.

Sub-Total

Package Discount* (Applicable for AIHQ Members Only)

CBK Course and Certification Exam - \$50.00

*Must register and submit payment at same time to be eligible for the package discount.

Grand-Total

Please submit all forms together.

Note: All prices effective 1-1-08 and are subject to change.

Payment Method:	
<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard
<input type="checkbox"/> American Express	<input type="checkbox"/> Check # _____
<input type="checkbox"/> Money Order # _____	
Credit Card #: _____	3-4 digit Security Code: _____ Exp. Date: _____
Signature: _____	Date: _____
<input type="checkbox"/> Fees Previously Paid	

EXMAPP

"Working as a non-clinical person in a clinical environment, it (HCQM Certification) has allowed me to work in a peer to peer relationship leading to success not only in the medical management arena but in the business side of healthcare. (I) believe it provides opportunities to increase education in current quality and patient safety movement."

Joanne H. Soublis, Director of Quality Management
 Diplomate since 1995

FORM B - HCQM Certification Exam Application Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

ABQAURP provides equal opportunity/access to all eligible exam candidates. Each candidate must meet the following criteria to be deemed eligible for the HCQM Certification exam:

- Hold a current, non-restricted license in each state or territory of the United States in which the candidate is licensed. If the individual's profession does not require a license, ABQAURP may determine eligibility based on experience and education.
- Complete a minimum of twenty (20) hours of ABQAURP approved continuing education (pertinent to at least one of the exam categories). Successful completion of ABQAURP's CBK Course (13 hours) fulfills this requirement.

Application must be typewritten or printed legibly and completed in full. Illegible applications will be returned. Attach additional sheets if necessary. Please indicate N/A where information is not applicable.

1. Name _____ 2. Gender M F
First Middle Initial Last

3. Social Security Number _____ 4. Date of Birth: _____
mm/dd/yyyy

5. Degree _____

6. Organization _____

Title: _____

Type of Organization: _____

7. Addresses Preferred: Home Business

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Home E-mail: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Business E-mail: _____

8. Hospital Affiliations/Current Organizations *(Please include current affiliation/organization in this section, if applicable.)*

Name and Type of Facility:	Address:
_____	_____
_____	_____
_____	_____

EXMAPP

Please Continue...

ABQAURP provides the only Health Care Quality Management & Patient Safety certification with definable standards.

FORM B - HCQM Certification Exam Application Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

9. Licensure Information (Items 9-11 to be completed by PHYSICIANS ONLY. NON-PHYSICIANS please skip to Item 12.)

State(s) in which you are licensed to practice (Attach current copy of each license):

State: _____ Year: _____ State: _____ Year: _____ State: _____ Year: _____

Primary Specialty: _____ Board Certified (year): _____

Board Eligible: Yes No

Secondary Specialty: _____ Board Certified (year): _____

Board Eligible: Yes No

10. Medical School

Name: _____ Year Graduated: _____

Address: _____

11. Post Graduate Training

Residency: _____ Institution: _____ Dates _____ to _____

Fellowship: _____ Institution: _____ Dates _____ to _____

Other: _____ Institution: _____ Dates _____ to _____

12. Education (Items 12-13 to be completed by NON-PHYSICIANS ONLY)

College: _____ Degree: _____ Year Graduated: _____

College: _____ Degree: _____ Year Graduated: _____

13. Post Graduate Education in Health Care Quality Management related field(s)

Course: _____ Location: _____ Sponsor: _____ Credits: _____

Course: _____ Location: _____ Sponsor: _____ Credits: _____

14. Health Care Quality Management work related activities* (ALL CANDIDATES)

Organization: _____ Title: _____ Dates: _____ to _____ Hours/Week: _____

Organization: _____ Title: _____ Dates: _____ to _____ Hours/Week: _____

Organization: _____ Title: _____ Dates: _____ to _____ Hours/Week: _____

* List additional experience from any of the exam categories. Use additional paper if necessary.

I became certified in Health Care Quality Management (HCQM) because ... this "official certification is an enhancement to my portfolio and my credibility."

Rachel S. Walker, RN
Diplomate since 1997

FORM B - HCQM Certification Exam Application Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

15. Health Care Quality Management References (Reviewed for acceptance by ABQAURP)

Please list below two (2) references for your professional Health Care Quality Management experience.

Name & Title: _____ Relationship: _____

Address: _____ Telephone: (_____) _____

Name & Title: _____ Relationship: _____

Address: _____ Telephone: (_____) _____

16. License Verification (IMPORTANT)

- a. Has your license to practice ever been suspended, revoked, modified, withdrawn or restricted? Yes No
- b. Have you ever been subject to disciplinary action by any hospital committee, county medical society, state/federal agency? Yes No
- c. Have your hospital privileges ever been adversely affected? Yes No

If you answered "yes" to any of the questions above, please submit a complete explanation and any supporting documents. Include copies of Complaint, Final Order and documentation from your State Medical Board indicating status of your license.

17. Sub-Specialty Certification

The eligibility requirements listed below are not subject to waiver. No payment is required, as long as the sub-specialty is chosen at the time this application is submitted.

ABQAURP provides equal opportunity/access to all eligible sub-specialty candidates. Applicants must meet the following criteria to be deemed eligible for the ABQAURP sub-specialty certification.

All candidates must:

- Achieve Diplomate status with ABQAURP by passing the certification exam; **AND**
- Provide documentation of active involvement (3 years experience, averaging 2 hours per week) within the last four years in candidate's chosen sub-specialty category: Patient Safety / Risk Management, Managed Care, Case Management or Workers' Compensation; **AND**
- Complete a minimum of 24 hours of ABQAURP approved continuing education (pertinent to the chosen sub-specialty category). Candidates must submit course description and certificate of completion for non-ABQAURP continuing education courses.

FORM B - HCQM Certification Exam Application Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

Sub-Specialty Options

Please check off the sub-specialty certification(s) for which you are applying:

List relevant active involvement in the sub-specialty applied for, use additional paper if necessary.

Patient Safety / Risk Management: _____

Managed Care: _____

Case Management: _____

Workers' Compensation: _____

EXMAPP

Please Continue...

How HCQM certification adds to my daily professional performance: "It makes me aware of issues related to medical practice but not taught in medical schools, such as quality assurance, error management, medical records management, peer review issues and many more."

Sarala A. Rao, MD
Diplomate since 1986

FORM B - HCQM Certification Exam Application Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

18. Exam and Application Fee

All fees are non-refundable.

I understand that I will be refunded the exam fee ONLY if ABQAURP declares me ineligible. Yes No

The fees are being paid by my employer. I am paying the fees personally

I understand that I will be charged \$60.00 by Prometric if I arrive too late for the exam, fail to bring proper ID or fail to meet the minimum time for rescheduling. Yes No

19. Additional Information

Please indicate how you initially heard of ABQAURP. If referred by an individual, please provide their full name. This allows us to thank them for their support. _____

20. Please indicate the primary reason for choosing this certification (please check one only):

- Required by Employer Preferred by Employer
- ABQAURP's Reputation NBME Affiliation
- Increased Knowledge Professional Advancement
- Increased Credibility Commitment to Health Care Quality and Patient Safety
- Other: _____

Did you remember to include:

- Copy of current, non-restricted license(s), if applicable (wallet card is acceptable)
- Copy of current curriculum vitae (resumé)
- Copies of any Complaints, Final Orders or documentation from your State Medical Board indicating the status of your license (include information only if you answered "yes" to question 15)
- Copies of certificates for Health Care Quality Management CE hours earned (if not using the ABQAURP CBK Course for the minimum education requirement)
- Copies of CE certificates for any sub-specialty certifications
- Your notarized signature on application form
- All applicable fees as noted on Form A (check or credit card and signature must be included)

EXMAPP

Please Continue...

FORM B - HCQM Certification Exam Application Form

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

Authorization Agreement

All candidates requesting HCQM certification must complete this section.

If I successfully complete the certification process and attain the HCQM designation, I authorize ABQAURP to release my name and contact information as a Diplomat. Yes No

I hereby authorize ABQAURP to obtain background information and I will hold ABQAURP harmless for any decision made by them based on this information. I understand that my Health Care Quality Management activities and reference sources must be acceptable to ABQAURP and that ABQAURP has the final decision on my eligibility.

I understand that to maintain my active Diplomat status, I must fulfill the continuing education requirement every two years and remain current with annual fees.

I understand that I, as a member, am bound by the Articles of Incorporation, Bylaws and Rules and Regulations set forth by ABQAURP. (<http://www.abqaurp.org/pdf/BYLAWS.pdf>)

I have carefully read the entire application and attest to the best of my knowledge that the foregoing statements are true. I understand that providing false information may be cause for denial or loss of the HCQM credential. Any intentional misrepresentation by me will result in my ineligibility to sit for the exam or revocation of my Diplomat status if the exam is successfully completed.

Applicant Signature (Required)

Affix Notary Seal Here >>>

State of _____

County of _____

Sworn and subscribed before me this _____ day of _____, 20_____

Notary Public Signature _____

Personally known _____ Produced identification _____ Type of ID _____

EXMAPP

I would recommend the ABQAURP Health Care Quality and Management (HCQM) certification to a colleague because ... "it is a nationally recognized certification that is respected amongst healthcare professionals."

Maryanne B. Gordon, MA, RHIA
Diplomat since 1983

AIHQ MEMBERSHIP APPLICATION

ABQAURP • 6640 Congress Street • New Port Richey, FL 34653 • (800) 998-6030 • (727) 569-0190 • Fax (727) 569-0195

Please Print or Type

NAME: _____ DEGREE: _____

GENDER: M F

EMPLOYER: _____ TITLE: _____

Please check preferred contact address

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ WORK PHONE: (____) _____

FAX: (____) _____ E-MAIL: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: (____) _____

FAX: (____) _____ E-MAIL: _____

AIHQ MEMBERSHIP ANNUAL FEE \$150

Visa MasterCard Check #: _____ Money Order #: _____

Credit Card #: _____ Exp. Date: _____

Signature: _____ Date: _____

Release:

I hereby grant permission to ABQAURP to release my name as an AIHQ Member. I agree to remain current on annual fees.

Signature: _____ Date: _____

EXMAPP

Fax: 727.569.0195
Mail: 6640 Congress Street, New Port Richey, FL 34653



ABQAURP would like to thank all health care professionals who have taken time to help improve health care quality and patient safety through continual improvement and certification.