Certified Correctional Health Professional

A program of the National Commission on Correctional Health Care

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APPLICATION FOR CONTINUING CERTIFICATION
(For Basic and Specialty Certifications)

Name:_______________ Title: ☐ Dr. ☐ Mr. ☐ Ms. ☐ Other _______________

Job title:_______________ Academic/professional credential(s): _______________

Primary employer: _______________

CONTACT INFORMATION

Mailing address:_______________ Primary phone: _______________

_______________ Mobile: _______________

Alternate address:_______________ Primary email: _______________

_______________ Other email: _______________

CONTINUING EDUCATION ACTIVITIES

To maintain CCHP certification, the CCHP Board of Trustees requires that you participate in at least 18 hours of continuing education each year, 6 of which are specific to correctional health care, during the past 1-year certification period.

- ✓ Number of **Category 1 hours** (CE activities specific to correctional health care): _______________
- ✓ Number of **Category 2 hours** (other CE activities*): _______________
- ✓ Total number of hours earned (must equal 18 or more): _______________

* Please refer to the recertification requirements specific to your certification on the NCCHC website.

RECERTIFICATION STATEMENT

I certify and, by my signature, attest that I have read and understand the eligibility requirements described in the guidelines for application for continuing certification found on the CCHP page of the NCCHC website and that I meet these eligibility requirements. If my eligibility changes, I will so notify the CCHP Board of Trustees. I further understand that any false statement or misrepresentation that I may make in these proceedings and application for continuing certification may result in the revocation of my certification. I also agree to indemnify and hold harmless NCCHC and the CCHP Board of Trustees, their officers, directors, employees and agents from any or all liability, loss or damage that may result from a denial of my application for continuing certification as a CCHP.

Signature_______________ Date _______________

DIGITAL BADGE

Do you want a digital badge? ☐ Yes ☐ No

FEES (SELECT ONE OPTION)

Print your own certificate ☐ $115 $_______________

Certificate mailed to you ☐ $130 $_______________

LATE FEE if submitted after expiration date: ☐ $25 $ _______________

I am paying by ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover **Total** $ _______________
☐ Check enclosed payable to CCHP Board of Trustees

Card number_______________ Security code_______________ Exp. date _______________

Billing address _______________

Authorized cardholder signature _______________

Print name_______________ Date _______________

Please send this form with your payment to: NCCHC, P.O. Box 623, Carol Stream, IL 60197-6233 Fax (773) 880-2424
Save $15 when you recertify online: www.ncchc.org/cchp