Certified Correctional Health Professional

A program of the National Commission on Correctional Health Care

1145 W. Diversey Parkway • Chicago, IL 60614
773-880-1460 • Fax: 773-880-2424 • cchp@ncchc.org

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 _____

FEES

Recertification by mail or fax (only $100 if completed online) ☐ $115 $ 115

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:
CCHP Board of Trustees
P.O. Box 6233
Carol Stream, IL 60197-6233
Fax (773) 880-2424
www.ncchc.org/cchp