

**Certified Correctional Health Professional
Application for Continuing Certification**

NAME AND PROFESSIONAL STATUS. Please print or type your name as you would like it to appear on all official documents.

Name: _____ M F Degree/Certification: _____

Job Title: _____

Primary work setting (check one):

- Advocacy County or city jail Dept of health Federal prison Federal - ICE Hospital
 State DOC State juvenile State prison University Other _____

Primary profession (check one):

- Administrator Attorney Dentist Nurse Nurse practitioner Pharmacist Physician
 Physician assistant Psychiatrist Psychologist Social worker Other _____

CONTACT INFORMATION FOR BUSINESS/WORK

Company/Facility Name _____ Department _____

Business Address _____ City _____ State _____ Zip +4 _____

Business Phone _____ Business Fax _____ Business Email _____

CONTACT INFORMATION FOR HOME

Home Address _____ City _____ State _____ Zip +4 _____

Home Phone _____ Home Fax _____ Home Email _____

PREFERRED MAILING. Home Business

DIRECTORY INFORMATION. As a CCHP, you are automatically enrolled in the Academy of Correctional Health Professionals. One of the many benefits of Academy membership is a listing in and access to the online membership directory, located in the members-only section of the Web site. Only fellow Academy members will be able to access the information. Your name, place of employment, and job title will appear as they are shown above. (Check only one.)

- Yes - Business.** Include my business contact information in the Academy online membership directory.
 Yes - Home. Include my home contact information in the directory.
 No. I do not wish to be included in the directory.

SHARED INTEREST GROUPS. Another benefit of Academy membership is the Shared Interest Groups (SIGs). The members-only section of the Academy Web site will enable you to communicate with others who have registered for the same interests. You may register for as many SIGs as you like.

- Administration Research Juveniles Legal Issues
 Infection Control Mental Health Public Health Quality Improvement
 Dental Nursing Peer Review

PAYMENT INFORMATION. The recertification fee is \$75. If submitted after the due date, a \$25 late fee must be added. Purchase orders are not accepted. Make checks payable to the CCHP Board of Trustees.

Please bill the Visa MasterCard American Express indicated below:

Name as shown on the card (Print): _____

Card #: _____ Expiration Date: _____

Signature: _____

Billing address (if different from mailing address): _____

Continuing Education Activities

Please list the dates, program titles and number of hours earned for each activity in which you participated during your current 1-year certification period. This is the period found on your current CCHP certificate. See the online list of frequently asked questions for detailed guidelines and instructions. If there is not enough room on this form, please attach a separate sheet.

CATEGORY 1: CONTINUING EDUCATION ACTIVITIES SPECIFIC TO CORRECTIONAL HEALTH CARE

Date (Month/Year)	Program/Course Title	Hours Earned
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Subtotal Category 1 (Must equal 6 hours or more)		_____

CATEGORY 2: GENERAL CONTINUING EDUCATION ACTIVITIES

Date (Month/Year)	Program/Course Title	Hours Earned
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Subtotal Category 2		_____
Total Number of Hours Earned (Must equal 18 hours or more)		=====

RECERTIFICATION STATEMENT

I certify and, by my signature, attest that I have read and understand the eligibility requirements described in the enclosed guidelines for application for continuing certification 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 the NCCHC and 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

Please send this form with your payment to
CCHP Board of Trustees
P.O. Box 11117
Chicago, IL 60611
Fax (773) 880-2424