Association of Clinical Documentation Improvement Specialists

2016 Examination Application

Certified Clinical Documentation Specialist (CCDS)

Please submit this application with the appropriate fee ($255 for current **ACDIS** members; $355 for non-members) to:

Attn: HCPro
Penny Richards
CCDS Program
35 Village Road, Suite 200
Middelton, MA 01949

This is an online application that you can fill in, save, and email to ccdsapp@acdis.org. Save your file in the following format, using your first initial and last name (see example below)

CCDS_EXAM_PRICHARDS

Fax 978/560-0934
Attn: Penny Richards

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

Length of time as a concurrent documentation specialist: _____

Current facility/company name: _____

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

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 Exam eligibility requirements.

Previous facility/company name: _____

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

Name: _____

EXAM

4. Current certifications

Please check which of the following certifications you currently hold.

☐ ACM	☐ BS	☐ BSN	☐ CCM	☐ CCS	☐ CIC	☐ CLNC
☐ CMAC	☐ CPC-H	☐ CPHQ	☐ CPUR	☐ CTR	☐ FNP	☐ LPN
☐ MBA	☐ MD	☐ MPH	☐ MS	☐ MSN	☐ RHIA	☐ RHIT
☐ RN	☐ Other, please specify:_____					

5. Release of examination results

ACDIS recognizes the achievement of all individuals who successfully complete the CCDS 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

Click this link to pay online, then fax or scan/email your application according to the instructions on the application. If you prefer you may pay by check and mail with the application.

7. Location of Exam

You will receive an email with instructions to schedule your exam at the AMP 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 certify that I have fulfilled one of the four required routes to take the exam and that the information provided by me on this application is accurate.

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 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: _____

