Certified Healthcare Protection Administrator (CHPA) Application

This application allows you to document activities and achievements you believe qualify you for the CHPA certification.

INSTRUCTIONS

Carefully read these instructions and each section of the application. You must document a minimum of ten (10) credits. Report all information on this form *and attach documentation when specified*. You do not need to provide documentation for any IAHSS-sponsored activity or service. The Commission may contact a sponsor to verify information or you to provide additional documentation.

Print clearly or type in each pertinent un-shaded area of the application.

Allow 45-days for the application evaluation process. The evaluation will take longer if required documentation is missing from the initial application.

If acceptance is denied, IAHSS will return the application, attachments, application fee, and a written explanation of the reason(s) for denial.

APPLICANT

Prefix (i.e., Mr.)		First		Middle	
Last				Suffix (i.e., Jr.)	
Mail Address #1					
Mail Address #2					
City		State/Prov.		ZIP	
Home Phone		Work Phone			
Primary Email		Secondary Email			

MEMBERSHIP; must be an IAHSS Senior or Partner member in good standing.

IAHSS Membership	Credit
Each full year	1
Maximum credits	**5**

Other Protection Association; may be a member of an IAHSS-recognized international or national protection organization within the past five (5) years.

Other Membership	Credit
Each full year	1
Maximum credits	**3**

ATTACHMENT REQUIRED: submit proof of Other Protection Association membership.				
Association Name		Year		
Association Name		Year		
Association Name		Year		

EDUCATION; only the highest earned degree applies; at least one (1) credit must come from this category.

Completed Degree	Credit
Minimum credit	**1**
High School / GED	1
Associate	2
Baccalaureate	3
Graduate	4
Maximum credits	**4**

ATTACHMENT REQUIRED: submit copy of diploma.			
Degree Earned		Year Earned	
Institution Name		City, State/Prov.	

EXPERIENCE; must be or have been in healthcare protection management within the past ten (10) years; at least one (1) credit must come from this category.

Full Service Years	Credit
Minimum; two full years	**1**
Each additional full year	1
Maximum credits	**5**

ATTACHMENT REQUIRED: submit letter(s) signed by immediate supervisor or Human Resources (on organization letterhead) confirming title(s) and appointment date(s).			
Position Title	Organization	Year(s)	

DEVELOPMENT; must have attended a protection training or education course; credit breakdown - less than 4 hours earns a half point, 4 -8 hour event earns one point, and more than 8 hours earns 2 points. IAHSS AGM full event counts for 3 points each year attended. At least one (1) credit must come from this category.

Course	Credit
Minimum credit	**1**
Each 5 contact hours	1
Maximum credits	**12**

IAHSS Course		Dates		
IAHSS Course		Dates		
IAHSS Course		Dates		
IAHSS Course		Dates		
IAHSS Course		Dates		
IAHSS Course		Dates		
IAHSS Course		Dates		
ATTACHMENT REQUIRED: submit proof of Other Protection Association training or education course.				
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		

AFFIRMATION

I affirm that each statement, answer, representation, and attachment of this application is accurate.			
Signature		Date	

SUBMISSION INSTRUCTIONS

Submit this completed application, required attachment(s), and the fee to:

IAHSS
PO Box 5038
Glendale Heights, IL 60139

Telephone: 630-529-3913

Staff/Certification Commission Review

(For Office Use Only)

TOPIC	MINIMUM CREDITS REQUIRED	MAXIMUM CREDITS ALLOWED	STAFF REVIEW	COMM. REVIEW
Membership	0	8		
Education	1	4		
Experience	1	5		
Development	1	12		
TOTAL EARNED				
MINIMUM TOTAL REQUIRED			**10**	**10**

Staff reviewer's signature		Date	
Comm. reviewer's signature		Date	

	Number	Dated	Mailed Date
Certificate			