



CERTIFICATION EXAM APPLICATION

1. Registration Information *PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.*

NAME: Last		First	Middle initial	Suffix/Credentials
ADDRESS:		City	State/Province	Zip Code/Postal Code
Country:	Home Phone:		Work Phone:	Ext.
Email Address:	Gender: Male Female	DOB: ____/____/____ MM DD YYYY		Exam ID #: (office use)

2. ACAM Membership

I would also like to join/renew my ACAM annual membership at this time.

NOTE: You must complete and submit an ACAM Membership application if you are joining ACAM for the first time or have modifications to your profile.

U.S. Membership

- Professional MD/DO Membership----- \$475.00
- Professional ND Membership----- \$390.00
Physicians licensed in: Alaska, Arizona, California, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maine, Montana, New Hampshire, Oregon, Utah, Vermont, Washington
- Associate Member----- \$295.00
Master-level Nurse, PA, PAC, Psychologist

International Membership

- Professional MD/DO Membership----- \$375.00
- Professional ND Membership----- \$290.00

3. Exam for which you are applying: (select only one)

- First time attempt (ACAM Member) ----- \$550.00
- First time attempt (Non – Member) ----- \$750.00
- CCT Recertification----- \$350.00

TOTAL: \$ _____

4. Payment Information – application must be accompanied by payment

Check or money order attached – payable to ACAM. US funds only.

Bill my credit card – **(circle one)** MasterCard Visa American Express Discover

Card # _____ Exp. Date (mm/yy) ____/____ CCV _____

Name on Card _____ Signature _____

Address of Payor (if different than applicant) _____



HONOR/ATTESTATION STATEMENT

1. **Applicant's Name:** _____
(Last) (First) (Middle)

2. **Exam ID #:** _____ (office use)

3. **Attestation Statement:**

First Time Applicant: Applies to the past 10 years

Recertification: Applies to the past 7 years

-Have you ever been found liable, or entered into a settlement that included an admission of liability, for professional malpractice, negligence, violation of informed consent, ethical misconduct, or other harm to a patient?

_____ No _____ Yes

-Has a state medical or other occupational board or hospital or other health facility ever made a finding, or have you entered into a consent agreement that included an admission of liability, that you violated any professional standard of care, regulation or ethical standard governing the practice of your profession?

_____ No _____ Yes

I attest that the above answers are true and correct. I agree to provide ACAM with the appropriate documentation regarding the aforementioned statements should ACAM request additional details.

Applicant's Signature

Date

4. **Honor Statement:**

To the best of my knowledge, the information contained in the application is true, complete, correct and is made in good faith. I understand that information supplied is **subject to audit** and failure to provide full and accurate information, or to respond to a request for further information, may be sufficient cause for ACAM to bar me from the exam, withhold or revoke certification, or take other appropriate action with regard to my certification status.

My signature on this form indicates my agreement to keep the contents of the exam confidential and not discuss the specific exam content with anyone except authorized ACAM representatives. By complying with and enforcing this obligation, I help maintain the integrity of the ACAM Certification Program and the value of its certification credentials.

Applicant's Signature

Date