Professional Association of Healthcare Coding Specialists

Certified Healthcare Coding Instructor Application

PLEASE TYPE OR PRINT YOUR NAME AS YOU WOULD WANT IT TO APPEAR ON YOUR CERTIFICATE.

Name: _____PAHCS Member #:_____

Home Address: _____ City/State/Zip: _____

Home Telephone: _____ Email: _____

Education Completed: High _____ Associate _____ Bachelor _____ Master _____ Other _____

PAHCS Certification Held _____

Number of years experience as a Healthcare Coder _____.

Name and Telephone # of last two employers:

(1)_____

(2)_____

Instructional Experience

1. Institution_____ Dates _____

   Course _____ # of Students_____

2. Institution_____ Dates _____

   Course _____ # of Students_____

I hereby attest that the above information is true and accurate to the best of my knowledge

SIGNATURE:_____

DATE: _____

PLEASE ATTACH TWO LETTERS OF RECOMMENDATION FROM ANY OF THE FOLLOWING:

- YOUR CURRENT INSTITUTION
- STUDENTS
- CURRENT PRACTICE INDICATING COMMUNICATION SKILLS, EDUCATION YOU PROVIDED, ETC.

Payment Information: *(Make checks payable to PAHCS.)*

☐ Exam Fee - $ 300

☐ Check ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover

PAHCS OFFICE USE ONLY:

Date _____ Approved YES NO

Approved by _____

Name on Card: _____

Address for Card: _____

Credit Card #_____Expiration Date _____Four Digit Card Code: _____

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