



Professional Association of Healthcare Coding Specialists
**PAHCS Academy and
 Examination and Membership Application**

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

Name: _____ PAHCS Member #: _____

CHECK ONE: Please mail related material to: Practice Address Home Address

Home Address: _____ City/State/Zip: _____

Home Telephone: _____ Home Fax: _____

Email Address _____

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

Name of Practice: _____ Speciality: _____

Practice Address: _____ City/State/Zip: _____

Practice Telephone: _____ Practice Fax: _____

Certification Specialty Examination: CERTIFIED MEDICAL CODING SPECIALIST (CMCS)

SIGNATURE: _____

DATE: _____

* NOTE: Exam must be taken within one year from date of completion of classes.

PAHCS OFFICE USE ONLY: <input type="checkbox"/> <input type="checkbox"/>	
Date _____	Approved YES NO
Approved by _____	

Payment Information: (Make checks payable to PAHCS.)

PAHCS ACADEMY (includes PAHCS membership & certification exam)

In full - \$1000

Payment Plan - \$500 down payment (must be approved by PAHCS prior to starting classes)

TOTAL AMOUNT \$ _____

Check Visa MasterCard AmEx Discover Name on Card: _____

Address for Card: _____

Credit Card # _____ Expiration Date _____ Four Digit Card Code: _____