



# The Professional Association of HealthCare Specialists

## Application

### PAHCS Membership and/or CPOM Examination

New Member Name \_\_\_\_\_ Professional Title(s) \_\_\_\_\_

Email address \_\_\_\_\_

Practice Name \_\_\_\_\_

Practice Address \_\_\_\_\_

Practice City/State/Zip \_\_\_\_\_

Practice phone \_\_\_\_\_ Practice Fax \_\_\_\_\_

Home address \_\_\_\_\_ Home phone \_\_\_\_\_

Home City/State/Zip \_\_\_\_\_

**CHECK ONE: Please mail PAHCS material to:**     Practice address     Home address

Education completed:     High school     Associate degree     Bachelor degree     Master degree     Other

Number of doctors at the practice \_\_\_\_\_ Specialty you are coding \_\_\_\_\_ # Years coding \_\_\_\_\_

I certify I am not sanctioned by the Office of Inspector General or on an Exclusions List under this or any other name.

Signature \_\_\_\_\_ Date \_\_\_\_\_

#### **Application for the PAHCS Certification Exam: (completely fill out this section)**

**I am applying to take the Management Certification Exam for Certified Practice Office Manager (CPOM)**

Location of exam \_\_\_\_\_ Date of exam \_\_\_\_\_

Professional reference #1 \_\_\_\_\_ Contact information \_\_\_\_\_

Professional reference #2 \_\_\_\_\_ Contact information \_\_\_\_\_

#### **PAYMENT INFORMATION:**

- I ONLY want to become a PAHCS member at this time, please charge \$120
- I am already a PAHCS member. ONLY charge me the examination fee of \$250
- I want to become a member and also register for the exam. I will pay \$350 for both

\_\_\_\_ Check (Make payable to PAHCS)     Visa     MasterCard     American Express

Credit card number \_\_\_\_\_ Expiration date \_\_\_\_\_

Print name of card holder \_\_\_\_\_

Address of card holder if not listed above \_\_\_\_\_

PAHCS Office use only:  
\_\_\_\_\_ approved

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*Visit our Web Site at <http://www.pahcs.org> • E-mail: [pahcs@pahcs.org](mailto:pahcs@pahcs.org)*