



INTERNATIONAL COMMISSION
ON HEALTH CARE CERTIFICATION

**ICHCC Application Form for the
Certified Elder Life Care Manager
Credential**

Name: _____, First _____ MI _____

Business Address: _____

City State & Zip _____, _____

Business Telephone: (____) _____ Business Fax: (____) _____

E-mail Address: _____

Mailing Address (if different from above):

City: _____, State: _____, Zip: _____

1. Education

Please attach a copy of your educational degree(s) and any other credential you wish to have recognized by the Commission.

Education Degree (Letter Designation:

Bachelors _____ Nursing _____

Masters _____ Doctoral _____

Education Institution:

Bachelors _____

Nursing _____

Masters _____

Doctoral _____

2. **Employment History** (Only apply the past 5 year work period)

Years Employed in **ANY** Professional Setting **Since** Attainment of Degree: _____

A. Professional Title and Current Employment Position: _____

Employer/Corporation Name: _____

Time Employed with Current Employer _____

B. 2nd Most Recent Employment/Professional Title: _____

Employer/Corporation Name: _____

Time Employed with Current Employer _____

C. 3rd Most Recent Employment/Professional Title: _____

Employer/Corporation Name: _____

Time Employed with Current Employer _____

3. Continuing Education Units/Training

Include training and education units acquired within the last 5 year period. Course or verification forms are required for each documented training program/course. A minimum of 120 hours is required to satisfy this section of the application. If applying as a graduate of the University of Florida, Capital, or the Kaplan program, a copy of your certificate of completion should be attached.

1) Program Title:**Date Attended:****Number of Units Awarded:****Awarding Board Name:** _____**2) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** _____**3) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** _____**4) Program Title:****Date Attended:****Number of Units Awarded:****Awarding Board Name:** _____

5) **Program Title:**

Date Attended:

Number of Units Awarded:

Awarding Board Name: _____

6) **Program Title:**

Date Attended:

Number of Units Awarded:

Awarding Board Name: _____

7) **Program Title:**

Date Attended:

Number of Units Awarded:

Awarding Board Name: _____

8) **Program Title:**

Date Attended:

Number of Units Awarded:

Awarding Board Name: _____

9) **Program Title:**

Date Attended:

Number of Units Awarded:

Awarding Board Name: _____

10) **Program Title:**

Date Attended:

Number of Units Awarded:

Awarding Board Name: _____

4. Testing Information

Testing is administered online and on-site. If you plan to take the exam online, you will need to provide the name, phone number, address and e-mail address of a proctor as well as a testing site where you will be accessing the Internet. The exam must be taken at a university, community college, Sylvian Learning Center, or public library. The password key will be sent to your proctor, and the proctor will supervise your testing experience.

Proctor Name: _____

Exam Site: _____

Address: _____

Phone Number: _____

Proctor E-mail: _____

If you are taking the exam on-site, either at the ICHCC main office or at a designated national site, please indicate the date and location below.

Exam Date: _____

Exam Site: _____

5. Exam Fees

Please attach a check or money order made payable to **ICHCC** totaling **\$445**. You may use your credit card by accessing the Secure-Pay application located on the ICHCC web site at www.ichcc.org. Please forward your notice for testing and payment to:

The International Commission on Health Care Certification (ICHCC)
13801 Village Mill Drive
Suite 103
Midlothian, VA 23113
Phone Number: (804) 378-7273
Fax: (804) 378-7267

PLEASE PRINT NAME AND CREDENTIALS EXACTLY ON THE LINE BELOW AS THEY SHOULD APPEAR ON YOUR CERTIFICATE

