AMERICAN CERTIFICATION AGENCY FOR HEALTHCARE PROFESSIONALS

P.O. Box 58
Osceola, IN 46561
TEL: (574) 277-4538
FAX: (574) 277-4624

Application for Certification as a CERTIFIED MEDICAL PRACTICE CODER INSTRUCTOR – CMPCI (ACA)

Print or type your name exactly as you want it to be on your certificate.

_____

Last name **First name** **Middle initial/name**

Information and Instructions to Applicant

1. Please type or print all information **except** where signatures are required.

2. Please check the eligibility requirements for certification approval on the next page.

3. Before submitting this application, make sure you have provided the following:

   _____ $150.00 application fee (must accompany the application or it will not be processed).
   _____ Proof of certification or state license.
   _____ Proof of graduation from medical practice coding training school, college or equivalent training program.
   _____ Proof of current CPR certification.
   _____ Current resume.
   _____ One written letter of reference attesting to experience in the healthcare environment, teaching and training of personnel in medical practice coding.
   _____ Proof of at least 10 hours of medical continuing education during the past year.
   _____ A detailed syllabus or course outline.
   _____ Completed application signed and dated by applicant and necessary deans and/ or supervisors.

4. All applications are subject to content verification and approval.

5. Ineligible applicants will be refunded the application fee minus a $50 processing fee.

6. Upon approval applicant will receive a certificate as a Certified Medical Practice Coding Instructor.

7. Instructor certification must be renewed annually by providing proof of 10 hours of medical continuing education and submitting a $50 recertification fee.

ELIGIBILITY REQUIREMENTS FOR INSTRUCTOR APPROVAL

1. Applicant shall be a graduate of an accredited high school or acceptable equivalent.

2. Applicant must meet the following requirements:

   A. Registered or certified medical practice coder, laboratory technologist/scientist/technician, certified phlebotomist, certified medical assistant or licensed/registered LPN/RN.

   B. Current CPR certification.

   C. A minimum of three years work experience in the healthcare environment with documented experience in performing medical practice coding.

   D. A minimum of one year documented teaching experience.

Part I. **PERSONAL INFORMATION**

Full Name_____ **Social Security Number**_____/_____/_____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone Number (_____**)**_____ **Work Phone Number (**_____**)**_____

Email Address _____

Part II. EDUCATION AND TRAINING

A. Secondary

Senior High School_____ **Dates attended**_____

Address_____ **Date graduated**_____

GED_____ **Date**_____ **City/State**_____

B. College or University

Name/Complete Address	Dates	Hrs. completed	Degree

C. Healthcare and/or Coding Training

The applicant's final transcript and/or certificate must be provided.

1. **Applicant Name** _____ **Birthdate** _____

School Name_____

Program Name_____ **Tel no:**_____

School Address_____

Course dates: From_____/_____/_____ **to** _____/_____/_____

2. **School Name**_____

Program Name_____ **Tel no:**_____

School Address_____

Course dates: From_____/_____/_____ **to** _____/_____/_____

PART III. **EMPLOYMENT EXPERIENCE**

Approved Healthcare and Coding Experience

All approved coding experience credited toward certification must be earned in an approved healthcare facility such as a hospital, physician office laboratory, independent laboratory, HMO, group practice, etc.

1. **Facility** _____ **Employment dates (mo. & yr.)**

Address:
_____ **From**_____/_____ **to** _____/_____

Position Held **Supervisor's Name** **Telephone number**

_____

2. **Facility** _____ **Employment dates (mo. & yr.)**

Address:
_____ **From** _____/_____ **to** _____/_____

Position Held **Supervisor's Name** **Telephone number**

_____

Part IV. **MEDICAL PRACTICE CODING COURSE CONTENT**

Name of facility where training is to be held _____

Address & Telephone # _____

Title of Course _____

# of classes per year _____ **# of students per class** _____

Total length of course _____**Hrs;** **Lecture Time** _____**Hrs;** **Student Lab Time**_____**Hrs**

Clinical Experience Time _____ **Hrs (If applicable)**

Names and addresses of primary clinical experience facilities:

1. _____

2. _____

3. _____

Person responsible for monitoring clinical experience _____

Address & Telephone # _____

PART V. **RECOMMENDATION FOR CERTIFICATION**

Please have supervisor, manager or dean sign this recommendation for certification.

Signature_____ **Date**_____

Title_____ **Address**_____

PART VI. **AGREEMENT**

I hereby give my authorization to the American Certification Agency for Healthcare Professionals to request necessary information from individuals, institutions, and/or organizations named herein to validate information for certification. I certify that the information given herein is true and correct, to my knowledge and belief, and realize that certification is subject to revocation for misrepresentation. If accepted as a certificant, I agree to uphold and abide by the Standards of Practice and Bylaws of the American Certification Agency for Healthcare Professionals.

Applicant's Signature_____ **Date**_____

Do not write in space below

Date application received_____/_____/_____ Date completed_____/_____/_____ Approved by_____

Application rejected by_____ Reason_____ Date notified_____/_____/_____

GRANTED CERTIFICATE #_____ Issue Date_____/_____/_____

RECERTIFICATION DATES:_____