



# Certified Correctional Health Professional

A program of the National Commission on Correctional Health Care

1145 W. Diversey Parkway • Chicago, IL 60614  
773-880-1460 • FAX: 773-880-2424 • cchp@ncchc.org

## APPLICATION FOR CONTINUING CERTIFICATION

Name: \_\_\_\_\_ Professional Training: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Gender: \_\_\_\_\_  
Primary Employer: \_\_\_\_\_

### CONTACT INFORMATION

Mailing address: \_\_\_\_\_ Alternate address: \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Primary Email: \_\_\_\_\_  
Fax: \_\_\_\_\_ Other Email: \_\_\_\_\_  
Mobile: \_\_\_\_\_  
Other: \_\_\_\_\_

### CONTINUING EDUCATION ACTIVITIES

To maintain your CCHP certification, the CCHP Board of Trustees requires that you participate in at least 18 hours of continuing education each year, 6 of which are specific to correctional health care, during the past 1-year certification period.

- ✓ Number of **Category 1 hours** (CE activities specific to correctional health care): \_\_\_\_\_
- ✓ Number of **Category 2 hours** (general CE activities): \_\_\_\_\_
- ✓ Total number of hours earned (must equal 18 or more): \_\_\_\_\_

### RECERTIFICATION STATEMENT

I certify and, by my signature, attest that I have read and understand the eligibility requirements described in the guidelines for application for continuing certification found on the CCHP page of NCCHCs website and that I meet these eligibility requirements. If my eligibility changes, I will so notify the CCHP Board of Trustees. I further understand that any false statement or misrepresentation that I may make in these proceedings and application for continuing certification may result in the revocation of my certification. I also agree to indemnify and hold harmless NCCHC and the CCHP Board of Trustees, their officers, directors, employees and agents from any or all liability, loss or damage that may result from a denial of my application for continuing certification as a CCHP.

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

### FEES

CCHP recertification fee:  \$75 \$ \_\_\_\_\_

Late fee if submitted after expiration date:  \$25 \$ \_\_\_\_\_

Optional:

Academy membership (CCHPs save 33%)  \$50 \$ \_\_\_\_\_

Academy scholarship contribution  \$10  \$25  \$50  Other \$ \_\_\_\_\_

### PAYMENT

I am paying by  Visa  MasterCard  American Express  Discover **Total** \$ \_\_\_\_\_  
 Check enclosed payable to CCHP Board of Trustees

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_ Security Code \_\_\_\_\_

Billing address: \_\_\_\_\_

Please send this form with your payment to  
CCHP Board of Trustees  
P.O. Box 11117  
Chicago, IL 60611  
Fax (773) 880-2424