Certified Healthcare Protection Administrator (CHPA) Application

Applications submitted incorrectly will be returned.
Carefully read these instructions and each section of the application. Print clearly or type in each unshaded area of the application. **You must document a minimum of ten (10) credits. Report all information on this form *and attach documentation identified by letters (A, B, C, etc.) which correlate to the section(s) for which you are claiming the credit(s).***

The CHPA application fee is $450 for IAHSS Members and $525 for Non-members. Payment and all required documentation must be received at the time of application submission.

Allow 45 days for the application evaluation process. The evaluation will take longer if additional documentation is required to verify information in the initial application.

If acceptance is denied, IAHSS will return the application, attachments, and the application fee less a $50 administrative processing fee along with a written explanation of the reason(s) for denial.

APPLICANT

Prefix (i.e., Mr.)		First		Middle	
Last				Suffix (i.e., Jr.)	
Mail Address #1					
City		State/Prov.		ZIP	
Mobile Phone		Work Phone			
Primary Email		Secondary Email			

A. MEMBERSHIP:

IAHSS Membership: Professional (formerly known as "Senior") or Partner member in good standing within the past five (5) years. There is no minimum membership requirement.

IAHSS Membership	**Credit**
Each full year	1
Maximum credits	**3**

Other Association Membership: Member in good standing of an international or national protection, safety or emergency management association recognized by IAHSS within the past five (5) years.

Other Membership	**Credit**
Each full year	1
Maximum credits	**3**

ATTACHMENT REQUIRED - Submit proof of other Association membership.				
Association Name		Year		
Association Name		Year		
Association Name		Year		

B. EDUCATION: only the highest earned degree applies; at least one (1) credit must come from this category.

Completed Degree	Credit
Minimum Credit	1
High School / GED	1
Associate	2
Baccalaureate	3
Graduate	4
Maximum credits	**4**

ATTACHMENT REQUIRED - Submit copy of diploma.			
Degree Earned		Year Earned	
Institution Name		City, State/Prov.	

C. EXPERIENCE: must be or have been employed by or contracted to work for a hospital as a healthcare protection leader within the past ten (10) years. At least one (1) credit (two full years) must come from this category.

Full Service Years	Credit
Minimum: two full years	1
Each additional full year	1
Maximum credit	**5**

ATTACHMENT REQUIRED - Submit letter(s) signed by immediate supervisor or Human Resources (on organization letterhead) confirming title(s) and appointment date(s).			
Position Title	Organization	Year(s)	

D. DEVELOPMENT: must have attended a protection, safety or emergency management training or education course within the past ten (10) years. Credit breakdown - less than 4 education hours earns a half credit, 4-8 education hours earns one credit, and more than 8 education hours earns 2 credits. IAHSS AC&E full event earns 3 credits each year attended. IAHSS chapter educational meetings count ONLY with documentation of an educational component. (Breaks, meals and social components of an event do not count towards education hours calculated.) Webinars of 1-4 hours in length count as a half credit, with a maximum of six (6) total credits from webinars. All development activities must be accompanied by documentation of proof of attendance in order to receive credit. At least one (1) credit must come from this category.

Course	Credit
Minimum credit	**1**
Maximum credits	**12**

ATTACHMENT REQUIRED - Submit proof of training or education course(s).				
IAHSS AC & E		Dates		
IAHSS AC & E		Dates		
IAHSS AC & E		Dates		
IAHSS Education		Dates		
IAHSS Education		Dates		
IAHSS Education		Dates		
IAHSS Education		Dates		
IAHSS Education		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		
Other Course		Dates		

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AFFIRMATION

I affirm that each statement, answer, representation, and attachment of this application is accurate.			
Signature		Date	

Submit this application, required attachment(s), and the fee of:
IAHSS Members $450, Non-members $525.

IAHSS
8420 W. Bryn Mawr Ave., Suite 1020
Chicago IL 60631
Telephone: 630-529-3913 Fax: 630-529-4139 Email: Nancy@iahss.org

Staff/Certification Commission Review

(For Office Use Only)

TOPIC	MINIMUM CREDITS REQUIRED	MAXIMUM CREDITS ALLOWED	STAFF REVIEW	COMM. REVIEW
Membership	**0**	**6**		
Education	**1**	**4**		
Experience	**1**	**5**		
Development	**1**	**12**		
TOTAL EARNED				
MINIMUM TOTAL REQUIRED			**10**	**10**

Staff reviewer's signature		Date	
Commission reviewer's signature		Date	

	Number	Dated	Mailed Date
Certificate			