



Certified Healthcare Protection Administrator (CHPA)

Recertification Application

INSTRUCTIONS

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 fifteen (15) credits earned within your recertification period. 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 recertification fee is \$150 for IAHS Members and \$175 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 required documentation is missing from the initial application.

If complete application and payment are not received in the IAHS office by your CHPA renewal date, you may be required to retake the CHPA certification examination and achieve a passing score in order to retain your certification. This would require completing the CHPA application (not the recertification application) and submitting the full fee of \$450 for IAHS Members, \$525 Non-members.

If your recertification application is approved you will receive a letter indicating your next recertification date. If your application is not approved, IAHS 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 INFORMATION					
NAME: (First/Middle/Last)				Prefix:	
				Suffix:	
Mailing Address:					
City:		State/Prov.:		Zip:	
Primary Email:		Secondary Email:			
Primary Phone:		Alternate Phone:			



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A. MEMBERSHIP: There is no minimum membership requirement. The maximum number of credits is six (6) for the membership category.

IAHSS membership: Professional (formerly known as “Senior”), Life or Partner member in good standing.

<u>Membership</u>	<u>Credit</u>
Minimum	0
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 three (3) years.

<u>Membership</u>	<u>Credit</u>
Each full year	1
Maximum credits	3

Organization		Year(s)	Office use
IAHSS			
ATTACHMENT REQUIRED - Submit copy of membership acceptance/confirmation for each non-IAHSS association membership			
Name			
Name			
Name			

B. EDUCATION: only applies if degree status has changed since your last recertification.

<u>Completed Degree</u>	<u>Credit</u>
Associate	2
Baccalaureate	3
Graduate	4
Maximum credits	4

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



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C. EXPERIENCE: employed by or contracted to work for a hospital as a healthcare protection leader **directly responsible for its day to day security operations management** within the past three (3) years.

Minimum credit **0**
Each service year 1
Maximum credits **3**

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

D. DEVELOPMENT:

- Less than 5 education hours earns a half credit
- 5-8 education hours earns one credit
- Multi-day education events earn ½ credit for less than 5 education hours and a full credit for more than 5 education hours per day
- 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
- General employer-required online training such as/but not limited to compliance review classes for safety & other annual compliance are not approved for eLearning credits

All development activities must be accompanied by documentation of proof of attendance in order to receive credit.

Minimum credits **5**
Maximum credits **15**

ATTACHMENT REQUIRED - Submit proof of training or education course(s).		Date(s)	Office use
IAHSS AC&E			
IAHSS Education			
IAHSS Education			
IAHSS Education			
IAHSS Education			



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IAHSS Education			
Other Course			
Other Course			
Other Course			
Other Course			

E. ACTIVITIES AND ACCOMPLISHMENTS: participation in an IAHSS-approved protection activity or completion of an accomplishment. Minimum credit 0.

Event	Credit
Each item	1
Each full year	1 or 2 (see table below)
Maximum credits	10

Submit proof of participation from IAHSS or other IAHSS recognized healthcare protection organization (including organization name, location, and date (s))			
	Description	Date(s)	Office use
1 credit each, maximum of 4 credits per item:			
	Educational program speaker, instructor, coordinator or moderator		
	Author article in a publication		
2 credits per full year of service as a volunteer leader with IAHSS (1 credit for at least 6 months of service):			
	Chapter Officer/Regional chair		
	Board/Council/Committee/Commission/Task force member		
1 credit per full year of service with another IAHSS-recognized healthcare or protection related organization:			
	Chapter Officer/Regional Chair		
	Board/Committee Member		



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AFFIRMATION

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

MAILING INSTRUCTIONS:
 Submit this completed application, required attachment(s), and the recertification fee of:
 IAHSS Members \$150, Non-members \$175 to:

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

Recertification Review
(For Office Use Only)

TOPIC	MINIMUM CREDITS REQUIRED	MAXIMUM CREDITS ALLOWED	STAFF REVIEW	COMM. REVIEW
Membership	0	6		
Education	0	4		
Experience	0	3		
Development	5	15		
Activities and Accomplishments	0	10		
TOTAL EARNED				
MINIMUM TOTAL REQUIRED			15	15

Staff reviewer's signature		Date	
Comm. reviewer's signature		Date	