

Professional Exams Application Form (CPAM, CCAM)

Date: _____ Name: _____
Print name as it should appear on certificate. (First, MI, Last)

Employer's Name: _____
Please be sure to include your company/hospital name.

Mailing Address: _____

City: _____ State: _____ Zip: _____

Business Phone: _____ Home Phone: _____

Email: _____
**Email is required to process application.*

National Member ID: _____

Local Chapter Name: _____

Chapter Certification Chair: _____

Would you like your facility to be notified if you are
awarded a certification? Yes No

Name & Title: _____

Business Phone: _____

Address: _____

Please list your last three employers:

1. Your Current Title: _____

Business Dates of Employment: _____

Address: _____

2. Your Title: _____

Business Dates of Employment: _____

Address: _____

3. Your Title: _____

Business Dates of Employment: _____

Address: _____

**The CPAM and CCAM exams are only available to AAHAM
members in good standing. Dual certification exam is only
available to current CPAMs or CCAMs.**

Select exam:

- CPAM (Hospital)
- CPAM Dual Certification (Hospital)
(for current CCAM Certified Examinee)
- CCAM (Clinic)
- CCAM Dual Certification (Clinic)
(for current CPAM Certified Examinee)

Preferred exam date: Last week of April
 Last week of September

Are you currently a CPAM or CCAM? No Yes

If yes, Certificate Number: _____

If this is a retake, when did you originally sit for the exam? _____

Please note: If it has been more than 18 months since you originally sat for
the CPAM/CCAM exam, you must retake the entire exam.

If this is a retake, which section(s) are you taking?

Section: 1 2 3 4

If you are applying for Dual Certification, when did you originally
become a CPAM or CCAM?

Spring: _____ (year) Fall: _____ (year)

Education Credits Being Claimed (if any) Year(s) _____

*(A candidate claiming credit for education must attach a certified statement of graduation from a
college or university, or a transcript of credits if not graduated.)*

SUBMITTING YOUR APPLICATION:

Mail application with check or money order to:

AAHAM National Office
11240 Waples Mill Road, Suite 200
Fairfax, VA 22030

Fax: 703-359-7562

FEES: \$200.00 for the full exam
\$50.00 for each section retake
\$125.00 for the dual certification exam

Make checks payable to: AAHAM - Tax ID#23-1899873

**Payment by Visa, MasterCard or AMEX is accepted online at:
www.aaham.org**

For Credit Card Payment: AMEX VISA MASTERCARD

Account Number: _____

Name: *as it appears on card* _____

Signature: _____ Ex. Date: _____

Billing Zip Code: _____

Application fees are non-transferable and non-refundable.

DEADLINE: Your application must be received by the
AAHAM National Office by:

March 1 for the Spring exams
August 1 for the Fall exams

You will receive a confirmation email from the AAHAM National
Office indicating your application's acceptance. You will be
contacted by your Chapter Certification Chair regarding the time
date and location of your exam.

QUESTIONS? Call the National Office at 703-281-4043, ext. 201

Please keep a copy of this application for your records.

I hereby declare that the statements contained in this application
are true and correct to the best of my knowledge.

Signature of Applicant