**THE AMERICAN INSTITUTE OF HEALTH CARE PROFESSIONALS**

**APPLICATION FOR FELLOWSHIP**

**Fellowship I have Qualified for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My Fellowship has been approved by AIHCP Administration:  \_\_\_\_\_ YES,  \_\_\_\_\_NO**

**I am Currently a Certified Member of AIHCP in my Specialty Practice: \_\_\_\_\_ YES,  \_\_\_\_\_NO**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you want a scanned copy of your certification e-mailed to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Certification with AIHCP**

**Current AIHCP Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Issue Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Certified Member Since: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(If you have re-certified with AIHCP input the date of your original certification)**

**Method of Payment- Application fee for your Fellowship certification is:**

**$250.00 US Domestic Students   
  
$275.00 International Students (Any students with a Postal Address outside the United States of America)**

**Fee includes USPS Priority Shipping with Tracking.**

**Checks payable to: AIHCP**

**Your Fellowship status remains as long as you maintain your Certification status in the AIHCP, Inc. by means of continued renewal of your original Certification.**

**Checks payable to: AIHCP**

**\_\_\_\_\_ Check**

**\_\_\_\_\_ Money Order**

**\_\_\_\_\_ Credit Card \_\_\_\_\_ Visa \_\_\_\_\_ MC \_\_\_\_\_ American Exp \_\_\_\_ Discover**

**Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, the undersigned, verify that this application is complete, and to the best of my knowledge, all information provided is factual and true. I understand that failure to provide the needed information and required documentation could likely lead to delays in the processing of this application. I further understand that if any information supplied on this application is proven false, that I will be denied consideration for Fellowship. I further understand that if at any time it is discovered that I have made false or untrue statements on this application, or misrepresented myself, or have provided fraudulent documentation to the AIHCP, that the AIHCP will rescind my certification and fellowship status.**

**Agreed:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**Mail To:  
  
The American Institute of Health Care Professionals  
1975 Niles-Cortland Rd. N.E. Suite #1  
Warren, Ohio 44484**

**or Fax to: 330-469-5003; or you may scan and email to:** [**info@aihcp.org**](mailto:info@aihcp.org)

**Check List for Completed Submission:**

1. **Completed Application**
2. **Your Certification Fee payment (check, money order, credit card)**
3. **Make sure your sign this application**
4. **Incomplete applications will not be processed**
5. **You will be notified of your Fellowship status within 14 business days**
6. **Note: do not submit this application unless you have successfully been approved for the Fellowship program.**