



NAHP Renewal Form

NAHP supports the ongoing professional development of its certificants. The mandatory renewal process provides certificants with the opportunity to demonstrate the retention, reinforcement and expansion of their knowledge and skills pertaining to new clinical advances as well as state of the art information over the full spectrum of the healthcare arena. Renewal

also provides encouragement to, and acknowledgement for, participation in ongoing professional development activities and lifelong learning. To support this purpose, the renewal requirements require continuing education and professional activities that enhance ongoing professional development, recognize learning opportunities, promote continuing competence, and provide a process for both attaining and recording professional development achievements. To maintain use of the NAHP credentials, certification must be renewed annually.

PLEASE INDICATE WHICH CREDENTIAL(S) YOU ARE RENEWING:

<input type="checkbox"/> NRCMA	<input type="checkbox"/> NRCCS
<input type="checkbox"/> NRCEKG	<input type="checkbox"/> NRCAHA
<input type="checkbox"/> NRCPCT	<input type="checkbox"/> NRCPhT
<input type="checkbox"/> NRCPT	<input type="checkbox"/> NRCST
<input type="checkbox"/> NRDA	

CANDIDATE INFORMATION

PERSONAL CONTACT INFORMATION		
First Name:	Last Name:	
Middle Initial:	Maiden Name:	
Personal Address:		
City:	State/Province:	ZIP Code:
Social Security Number or Certification Number:		
Email Address:		
EMPLOYMENT INFORMATION		
Certificant's Job Title:		
Organization Name:		
Organization Address:		
City:	State/Province:	ZIP Code:
Phone:		

RESPONSIBILITY STATEMENTS

- I understand that the NAHP Renewal Form must be received on or before my renewal date.
- I have read and understand all the policies and procedures in the Candidate Handbook.
- I have read and accept the terms and responsibilities outlined in the NAHP Code of Ethics and Standards of Practice and continuing education standards as set forth by the Certification Council. Please see "Candidate Handbook" on website.
- I declare that all the information I have provided on all pages of this form is true and accurate. I understand that misrepresentations or incorrect information provided to NAHP can result in disciplinary action(s), including suspension or revocation of my eligibility, examination score, or credential.

Signature: _____	Date: _____
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FEES AND PAYMENT

The annual renewal dues fee is \$55 for the initial credential and \$25 for each credential thereafter.

If your renewal fee is paid after the original due date, a \$25.00 late fee must be added to the total due or your renewal will not be processed.

TOTAL FEE: \$ _____

Money Order or Check Payable to NAHP

Please charge my credit card: Visa MasterCard

Credit Card Number: _____

Expiration Date: ____/____

Cardholder Name: *Print clearly* _____

Cardholder Billing Address: _____

Signature of Cardholder _____

Cardholder Email Address: _____

Please submit forms to: National Association for Health Professionals (NAHP)
PO Box 459
Gardner, Kansas 66030 or
Fax to: 913-856-6125