



*The American Institute Of
Outcomes HealthCare Management*
6571 Altura Blvd, Buena Park, CA 90620
Telephone (562) 945-9990 Facsimile (562) 698-2339
www.aiocm.com

RE-CERTIFICATION APPLICATION

1	GENERAL INFORMATION		
Dr. Ms. Mr. Mrs. Please circle one of the above		_____ Certification Number	
First	Middle	Last	
Street Address			Apartment #
City	State	Zip	
Telephone	Fax	E-Mail	

2	CURRENT EMPLOYER		
Name of Employer			
			Dept.
Street Address			Suite #
City	State	Zip	
Telephone	Fax	E-Mail	

3	AREAS OF INTEREST
Please list areas in Outcomes-Case Management that you are interested in.	

PLEASE ANSWER THE FOLLOWING:

Has your professional license/certification ever been involuntarily or voluntarily revoked, suspended, restricted or has there been any other disciplinary action against you in any state? _____ Yes _____ No

Have you ever been convicted of any felony or misdemeanor, except for minor traffic infractions, under the laws of any state of the United States? _____ Yes _____ No

Has any disciplinary action been taken against you by any peer review body, healthcare organization, professional society, law enforcement agency, court of governmental agency pertaining to your clinical or ethical performance as a healthcare professional? _____ Yes _____ No

4	COMPLETED FURTHER EDUCATION (Completed within last two years)		
College/University	Degree/Diploma	Major	Year Received
Professional License	License #:	State:	

5	GENERAL PROFESSIONAL EXPERIENCE (Attach current resume, if desired)		
Please provide the following information for your current position held.			
Employer			
Position Title		Dates	From: To:
Job Description			
Additional information can be attached to the application.			

6	OUTCOMES CASE MANAGEMENT EDUCATION (Completed within last two years)		
Using this or other formats, on a separate page , outline any educational programs relevant to outcomes-case management you may have taken in the last 2 years.			
Program Name:			Program Provider:
Duration of Program:			Date Program Completed:
Brief description of program and program objectives, Or you may submit a copy of the program brochure or manual.			

7	SIGNATURE		
I, the undersigned, do hereby make this voluntary application for re-certification and understand that the information that I have provided is accurate, true and correct to the best of my knowledge. I agree to release to AIOCM all pertinent information related to my application. Therefore, I understand and agree that my failure to provide accurate, true and correct information shall constitute grounds for rejection of my application. I understand that my name will become part of the registry of AIOCM, unless I specifically request that my name not be released. In addition, I understand that failure to abide to the code of ethics shall constitute grounds for revocation of my certification. I understand that the certification is not a license.			
Signature		Date	

8	CHECKLIST		
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- Signed and completed entire application. **(If any part of the application is not signed or filled out, your application will be delayed).**
- Fees: \$125.00 (\$50.00 re-certification application fee is non-refundable and \$75.00 annual membership fee).
- Supporting documentation for re-certification. (i.e. certificates of attendance, published articles, etc).