National Headache Foundation (NHF) Certificate of Added Qualification in Headache Medicine Examination Application

After reading everything in its entirety, please complete all sections of this application. Mail or fax the completed application, required documentation, and payment (made payable to the National Headache Foundation) to:

Mail:
National Headache Foundation
1235-A Clybourn Ave.
Box #413 Chicago, IL 60610

Fax:
(312) 640-9049

1. PERSONAL INFORMATION

Name (with certifications, such as MD, NP, etc.)

_____

(As you wish it to appear on your examination records and certificate.)

Last four digits of Social Security Number: _____

Daytime Telephone Number: _____ Evening Telephone Number: _____

Email Address: _____ (Required for all applicants)

Home Street Address (Not a P.O. Box): _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

2. ELIGIBILITY

❑ I am a licensed healthcare provider. (Enclosed copy of current license.)

❑ Physician (M.D.) ❑ Physician (D.O.) ❑ Physician Assistant

❑ Nurse Practitioner ❑ Dentist ❑ Psychologist

Specialty (if applicable): _____

❑ NHF membership
(Your membership status will be verified by NHF.)

2b. **How did you hear about the CAQ (Certificate of Added Qualification)Exam -**

_____

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3. REQUIREMENTS

1. Do you have a valid and unrestricted license to practice in your field?

❑ Yes ❑ No

State Issuing License: _____ License Number: _____

2. Have any adverse circumstances occured that prevent you from obtaining malpractice insurance?

❑ Yes ❑ No

3. Have you ever been convicted of a felony?

❑ Yes ❑ No

4. If you answered "Yes" to questions 2-3, please explain:

_____

_____

5. Please include a letter from a colleague verifying three or more years involved in headache medicine.

4. EXAMINATION FEE

Payment should be made payable to NHF. All fees must be in U.S. funds drawn on a U.S. bank.

Examination Fee **Late Application Fee**

❑ NHF Member: $600 ($300 for NPs & PAs) ❑ Non-member: $800 ($500 for NPs & PAs) ❑ Late fee: $75

If payment is made by credit card, complete the following:

❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Credit Card Number: _____ CVS/CWZ (Security Code on Card): _____

Name on Card: _____

Cardholder's City, State/Province: _____ Cardholder's Country, Zip/Postal Code: _____

Card Expiration Date: _____ Cardholder's Signature: _____

5. EXAMINATION FEE

I certify that I have read all portions of this application. I certify that the information submitted in this application and the documents enclosed are correct to the best of my knowledge and belief. I understand that, if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed or voided, not released, or invalidated by NHF.

Name (Please Print): _____

Signed: _____ Date: _____