

National Headache Foundation Certificate of Added Qualification In Headache Medicine Examination Application

(Page 1 of 3)

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

Mail: _____ **Fax:** (312) 640 – 9049 **Email:** vstevens@headaches.org

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

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 Phone Number: _____ Evening Phone Number: _____

Email Address (Required for all applicants): _____

Home Street Address (No P.O. Box): _____

City: _____ State/Province: _____

Postal/Zip Code: _____ Country: _____

2. BUSINESS INFORMATION

Business Street Address (No P.O. Box):

City: _____ State/Province: _____

Postal Code: _____ Country: _____

3. ELIGIBILITY

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

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

Nurse Practitioner Dentist Psychologist **NHF Membership**

Specialty (If applicable) _____

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

Mailing Conference NHF Website Colleague Email

4. 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 occurred 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

NHF Member - Drs: \$600 **NHF Member – NPs & PAs: \$300**

Non-member – Drs: \$800 **Non-member – NPs & PAs: \$500**

Late Application Fee: \$75

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

Visa MasterCard American Express Discover

Credit Card Number: _____ CVS/CWS (Security Code): _____

Name on card: _____

Cardholder's City, State/Province: _____ Cardholder's Country: _____

Cardholder's Zip/Postal Code: _____ Card Expiration Date: _____

Cardholder's Signature: _____

5. VERIFICATION

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)

Signature:

Date:
