

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

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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](mailto: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.)

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

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):

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City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Website: \_\_\_\_\_

### 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) \_\_\_\_\_

#### 3b. How did you hear about the CAQ (Certificate of Added Qualification) Exam?

Mailing  Conference  NHF Website  Colleague  Email  Online

### 4. REQUIREMENTS

A. Do you have a valid and unrestricted license to practice in your field?  Yes  No

State Issuing License: \_\_\_\_\_ License Number: \_\_\_\_\_

B. Have any adverse circumstances occurred that prevent you from obtaining malpractice Insurance?

Yes  No

C. Have you ever been convicted of a felony?  Yes  No

D. If you answered "Yes" to questions 2 – 3, please explain:

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

### 5. 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: \_\_\_\_\_

## 6. 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: \_\_\_\_\_