



## National Headache Foundation Certificate of Added Qualification In Headache Medicine (AQH) - Examination Application

Mail, fax or email the completed application, required documentation, and payment (made payable to the National Headache Foundation (NHF)) to:

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

**Fax:** (312) 640 – 9049

**Email:** [vstevens@headaches.org](mailto:vstevens@headaches.org)

### 1. PERSONAL INFORMATION

Name (with certifications, such as M.D., N.P., etc. **limit two**)

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(As wish your name to appear on the certificate and examination records)

Daytime Phone Number: \_\_\_\_\_ Evening Phone Number: \_\_\_\_\_

Email (Personal Email Required): \_\_\_\_\_

Home Street Address (No P.O. Box): \_\_\_\_\_

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

Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

### 2. BUSINESS INFORMATION

Business Name and Address (No P.O. Box): \_\_\_\_\_

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

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): \_\_\_\_\_

Doctor's do you have UCNS?  Yes  No

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

Mailing  Conference  NHF Website  Colleague  Email  Online

**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:

\_\_\_\_\_  
\_\_\_\_\_

**\* Please include a letter from a medical 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 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:

\_\_\_\_\_