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

1. PERSONAL INFORMATION

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

_____

(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. ELIGIBILTY

__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:

_____