



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

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 MD, NP, etc. **limit two**)

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

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:

- License must be in good standing
 - Please submit documentation of 20 hours CME/CEU credits in headache medicine over the last year
- Meet one of the following options:
- At least one or more years of experience at a headache clinic or Headache Center of Excellence (HCoE), **subject to review by NHF's AQH Oversight Committee**, or
 - At least three years of experience managing headache medicine in other clinical settings, or
 - A professional who has completed an accredited neurology residency (MD or DO)
 - A professional who has successfully completed a headache fellowship, as approved by the NHF's AQH Oversight Committee.

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 (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:
