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**: AQH@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. ELIGIBILTY

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

___Physician (M.D.) ___Physician (D.O) ___ Physician Assistant ___Nurse Practitioner

___Dentist __ Psychologist ___ Pharmacy____Other: _____

Specialty (If applicable)_____

Doctors: Do you have **UCNS?** ___ Yes ___ No

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

___ Conference ___ NHF Website ____Colleague ____ Email ___ Online ___Mailing

4. REQUIREMENTS (a copy of license, resume and colleague letter on professional stationary)

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 submit documentation of 20 hours CME/CEU credits in headache medicine over the last year. In addition, a professional colleague letter and resume verifying one or more of the following experience criteria: one or more years of experience at a headache clinic or Headache Center of Excellence, 3 years of experience managing headache medicine in clinical settings, completion of an accredited Neurology residency (MD/DO) or completion of a headache fellowship.**
    - **The items highlighted in red are subject to review by the NHF's AQH Oversight Committee.**

5. EXAMINATION FEES

- **Note: AQH certification is for X years**
- **Quantity options are for practitioners within same office, or same corporation**

Quantity of 1 people: ____MD/DO: $TBD ____ NP/PA/Other: $TBD
Quantity of 3 people in same year: ____MD/DO: $TBD ____ NP/PA/Other: $TBD
Quantity of 5-9 people in same year: ____MD/DO: $TBD ____ NP/PA/Other: $TBD
Quantity of 10+ people in same year: ____MD/DO: $TBD ____ NP/PA/Other: $TBD

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: