



Continuing education submission form

Personal information

CCDS ID Number: _____
Name: _____
Home address: _____ Home Phone: _____
City/State/Zip: _____ Cell: _____
Company Name: _____ Work Phone: _____
Company Address: _____
Company Address 2: _____ Work Fax: _____
City/State/Zip: _____
E-mail: _____

ACDIS member: Yes No

Please check the mailing address that you would prefer to receive CCDS correspondence:

Home Work

Method of payment—Credential maintenance fee

Check Money Order Credit Card

Visa MasterCard American Express Discover (circle one)

Credit Card Number: _____ Expiration Date: _____

Signature: _____

Name as it appears on Credit Card: _____

Attestation Statement

I verify the truth of the information submitted on this Continuing Education Submission Form. I affirm that I participated in continuing education activities and that the number of units reported is correct. If audited, I will supply supporting documentation verifying participation and summarizing content for all CEUs.

Signature: _____ Date: _____

Submit to:

HPro, Inc.
Attention: Certified Clinical Documentation Specialist Program
P.O. Box 1168
Marblehead, MA 01945
Tel: 877/240-6586
Fax: 800/738-1553

ADMINISTRATIVE USE ONLY	
<input type="checkbox"/> CS	CPM: Date Processed
<input type="checkbox"/> PP	
<input type="checkbox"/> Sent to CPM	