

**THE AMERICAN INSTITUTE OF HEALTH CARE PROFESSIONALS, INC.**

**CENTER FOR CONTINUING PROFESSIONAL EDUCATION**

**APPLICATION FOR APPROVAL**

**Date of Application:** \_\_\_\_\_

**Name of Person Submitting Application:** \_\_\_\_\_

**Organization:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email of Contact Person:** \_\_\_\_\_

**Type of Application:** \_\_\_\_\_ **Continuing Education Program**

\_\_\_\_\_ **Continuing Education Seminar**

\_\_\_\_\_ **College Course**

\_\_\_\_\_ **Distance Learning Continuing Education Program**

\_\_\_\_\_ **Distance Learning College Course**

\_\_\_\_\_ **Independent Study**

\_\_\_\_\_ **Skills Workshop**

\_\_\_\_\_ **Staff Inservice/Education**

\_\_\_\_\_ **Other: describe:**

**Applying for Approval from:** \_\_\_\_\_ **American College of Legal Nurse Consulting**

\_\_\_\_\_ **American Academy of Grief Counseling**

\_\_\_\_\_ **American Academy of Case Management**

\_\_\_\_\_ American College of Hypnotherapy

\_\_\_\_\_ American Institute of Health Care Professionals

1. Title of the Program: \_\_\_\_\_

2. Dates Program will be offered: \_\_\_\_\_

3. Number of Hours of Instruction (one hour = 50 minutes of presentation or study): \_\_\_\_\_

4. Name of Faculty for this course or program: \_\_\_\_\_

5. Credentials of Faculty: \_\_\_\_\_

6. Sponsoring Organization: \_\_\_\_\_

7. Course Description:

8. Course or Program Objectives:

9. Course Content:

10. Method of Instruction:

11. Means of Evaluation: (provide a copy of the evaluation form)

12. Course or Program Certificate:(provide a copy of the certificate that will be given to participants)

**PLEASE CAREFULLY REVIEW THE INFORMATION ON THE WEBSITE: “Submitting an Application for Program/Offering Approval”**

**PLEASE CAREFULLY REVIEW THE “Standards for Program/Offering Approval” and please follow these standards in the preparation of this application.**

Summary of Instructions:

- 1) You may copy this form and paste into a Word Processor for ease of completion.
- 2) All applications must be type-written.
- 3) Submit two copies of your application.
- 4) You must submit the evaluation form and a copy of the certificate you will provide learners.
- 5) For hours translation, one contact hour = one 50 minute period of presentation/study.
- 6) One semester hour of college credit = 15 contact hours
- 7) Please follow the standards (below) as provided by AIHCP when completing your application.
- 8) Payment must accompany the application.
- 9) Once approved, the approval will be for a three year period.
- 10) Completed applications are to be sent to:

The American Institute of Health Care Professionals, Inc.  
2400 Niles-Cortland Road, S.E. Suite # 3  
Warren, Ohio 44484

Fees for Approval

The fee for program/offering review and approval is \$50.00 for all programs and offerings up to 100 hours of instruction/study. The fee for programs/offerings over 100 hours is \$75.00. If a program is not approved, the applicant will be refunded the fee, minus a \$25.00 review cost.

Method of Payment

Application fee payment method:

\_\_\_\_\_ Check (payable to AIHCP)

\_\_\_\_\_ Money Order (payable to AIHCP)

\_\_\_\_\_ Credit Card \_\_\_\_\_ Visa \_\_\_\_\_ MC \_\_\_\_\_ American Express

Card Number: \_\_\_\_\_

Expiration: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

I, the undersigned, verify that this application is complete, and to the best of my knowledge, all information provided is factual and true. I understand that failure to provided the needed information and required documentation could likely lead to delays in the processing of this application. I further understand that if any information supplied on this application is false, that I will be denied consideration for approval. I further understand that if at any time it is discovered that I have made false or untrue statements on this application, or misrepresented myself or an organization, or have provided fraudulent documentation to the AIHCP, that the AIHCP may rescind the application or approval.

Agreed:

Signature of Representative: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Office Use Only:**

Received: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Approved: \_\_\_\_\_

Denied: \_\_\_\_\_

Approval # : \_\_\_\_\_

