

**AMERICAN BOARD OF HEALTH PHYSICS
AMERICAN ACADEMY OF HEALTH PHYSICS
1313 DOLLEY MADISON BOULEVARD, SUITE 402, McLEAN, VA 22101**

APPLICATION FOR RENEWAL OF CERTIFICATION

Name
(last) (first) (middle) (previous last)*

Addresses

Home	Business
<input type="text"/> address1	<input type="text"/> address1
<input type="text"/> address2	<input type="text"/> address2
<input type="text"/> <input type="text"/> <input type="text"/> city state postal code	<input type="text"/> <input type="text"/> <input type="text"/> city state postal code
<input type="text"/> <input type="text"/> country phone	<input type="text"/> <input type="text"/> country phone

Preferred mailing address: Home Business **E-mail**

Professional employment

Name of your current employer:

Position title:

Current supervisor:

Supervisor's Phone Number: **e-mail address:**

Are you currently:

- a. engaged in health physics at a professional level more than 25% of the time? Yes No
- b. a full-time student in a field related to health physics? Yes No
- c. a retired individual whose limited work time is devoted to health physics? Yes No
- d. a manager with primary responsibility for an organization that includes health physics? Yes No

Since your last recertification / initial certification

On average, were you engaged in the practice of health physics at a professional level more than 25% of the time? Yes No

I certify that the statements above (including any attachments I have submitted hereto) are, to the best of my knowledge, accurate, and I understand that any falsification of information in this application will be cause for rejection of the application or withdrawal of a certification already made.

I acknowledge that I understand and accept the statement of [Standards of Professional Responsibility for CHPs](#). By my signature below, I verify that as a Certified Health Physicist I will fulfill these responsibilities and, to provide additional assurance that I remain professionally competent, I agree to meet the requirements for continuing certification established by the Board.

Signature: **Date:**

* Please advise us if your legal name has changed since your initial certification / most recent recertification.

AAHP Continuing Education Committee approved continuing education courses attended during current renewal period.

Sponsor	Course Title	Location Offered	Date	Course Approval #	# of CECs Awarded
				Total:	

NOTE: Do not submit application until a minimum of 64 continuing education credits have been earned within your current renewal period.