Certified Healthcare Leader (CHL) certification is designed to recognize individuals who have demonstrated the management and supervisory skills necessary to provide effective leadership in the Central Service Department. CHL's are indispensable members of the healthcare team who are responsible for managing the daily operations of the Central Service Department including standards and regulation compliance, finance, reporting, staffing, human resource management, and inter- and intra-departmental communications.

To earn CHL certification, candidates are required to demonstrate skills through the successful completion of an examination developed to measure the understanding of general central service, infection prevention, and management topics. CHL certificants are required to recertify annually through completion of continuing education requirements.

Please Note: Full CRCST certification is required before applying for the CHL.

Once your application and payment have been received by IAHCSMM, processing will typically take 5-7 business days. Information on your exam eligibility period, scheduling your exam, available testing dates and locations, and the testing process will be mailed to the address provided in Section One. Please allow an additional 3-5 business days for this information to be delivered by the US Postal Service. You may also request the information be sent to you electronically by providing your email address(es) in Section One. Email notifications will be sent within 24 hours of application processing. (Scheduling information cannot be given by phone.) Once you receive your scheduling letter/email, it is your responsibility to schedule your exam.

SECTION ONE – Applicant Information (To Be Completed By the Applicant)
Please Note: Incomplete or illegible applications can delay processing, clearly print all information

First Name: _______________________________ Last Name(s): _______________________________
(As it appears on your primary government issued photo ID) (As it appears on your primary government issued photo ID)

Street Address: ___________________________________________ Apt/Floor/Lot/Unit: __________________________

City: ___________________________ State/Province: _________ Zip/Postal Code: _______________ USA or Canada

Current Facility (if employed): ___________________________________________________________ IAHCSMM ID# _________________________
(Leave blank if unknown)

Current Position (circle one):         Student         Technician         Supervisor         Manager         Educator         Other: ____________________________

Home or Cell Phone: (___________)_______________________ Work Phone: (___________)_______________________ Ext: __________________

Primary/Preferred Email: ___________________________________________ Secondary/Alternate Email: ______________________
(Optional) (Optional)

Your exam scheduling information will be mailed to your home address, as listed above, and also emailed, if email is provided above.

SECTION TWO – Payment Information (To Be Completed by the Applicant or Payment Provider)
Please Note: IAHCSMM cannot accept purchase orders of any kind; payment must be submitted along with this application

The examination fee within the United States & Canada is $125 USD. Payment must be submitted, along with this application, in the form of:
Credit/Debit Card (US & Canada), Money Order (US & Canada), or Check (US only.) Payment cannot be made by phone.

☐ I am submitting a check or money order, made payable to IAHCSMM, by mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601
☐ I am submitting the credit/debit card information below and give permission for my card to be charged $125 USD:
Fax to: 1-312-440-9474, Scan & Email to: certification@iahcsmm.org, or Mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601

Credit/Debit Card Holder’s Printed Name: _______________________________________________________

Credit/Debit Card Number: ________________________________________________________________ Expiration: _______________ (Month/Year)

Credit/Debit Card Holder’s Signature: ______________________________________________________ CV2#: _______________
(Handwritten Signature Required)
**SECTION FOUR – Background Requirements**

Current and full CRCST status is required in order to apply for the Certified Healthcare Leader Exam. If you do not already hold full CRCST status then you would need to achieve it before you apply to take the CHL test.

**SECTION FOUR – Statement of Understanding (To Be Completed By the Applicant)**

Please Note: Your signature in this section is mandatory in order to test with IAHCSMM

**Statement of Understanding**

I hereby apply to take the CHL exam. By signing below and submitting an exam application and fee, I attest that I have read and understand the IAHCSMM Certification Handbook (available online at IAHCSMM.org) and agree to abide by the certification program’s policies and procedures, and adhere to the Association’s code of conduct. I agree to inform IAHCSMM, without delay, of any matter that affects my ability to fulfill the certification requirements.

I further certify that the information provided by and about me on this form (and any other subsequent documentation submitted in relation to my certification) is accurate and correct. I understand that the information I provide to IAHCSMM may be audited for verification. I agree to provide any information necessary to verify my experience and authorize IAHCSMM to make any necessary inquiries in this regard. I understand that providing information on this or any document relating to my certification which is determined to be false or purposefully misleading, or in violation of any portion of the Code of Conduct and/or other policies and procedures, may result in disciplinary action, including the possible denial or revocation of certification, as outlined in the disciplinary policy.

**Release of Exam Results**

I understand that a Pass/Fail notice will be issued at the testing center upon completion of the exam, and that IAHCSMM will only release my full exam results directly to me, at the home address provided herein. Results are not available orally or electronically, and can take up to two weeks to be delivered. Exam results and pass/fail notifications will not be provided to 3rd parties without my prior express written consent. Upon request IAHCSMM will verify an individual’s current certification status (including their certification effective and expiration dates) to any inquiring party, but will not release the details of an individual’s examination(s), including exam scores and the number of exam attempts.

**Use of Personal Information**

The information provided to IAHCSMM on this form, and in regard to my certification exam, will be used in accordance of IAHCSMM’s Confidentiality Policy, included in the Certification Handbook and available online at IAHCSMM.org. I request and am granted special testing accommodations IAHCSMM may disclose personal information to third parties as necessary to administer my examination. This may include such information as my disability status, medical condition, or any political, religious, or philosophical beliefs which require accommodation. If IAHCSMM is required by law to disclose confidential information, the individual(s) whose information is released will be notified to the extent permitted by law.

**Non-Disclosure Agreement**

This examination is confidential and proprietary. It is made available to me, the examinee, solely for the purpose of becoming certified in the technical area referenced in the title of this exam. I am expressly prohibited from recording, copying, reproducing, disclosing, publishing, or transmitting this examination, in whole or in part, in any form or by any means, verbal or written, electronic or mechanical, for any purpose.

Printed Name: __________________________ Signature: __________________________ Date: __________

(Handwritten Signature Required)

IAHCSMM complies with the Americans with Disabilities Act (ADA) and is interested in ensuring that no disabled individual is deprived of the opportunity to take an examination solely by reason of that disability. IAHCSMM will arrange to provide special testing accommodations for those individuals with a condition or disability as defined under the ADA. Accommodations will be provided at a designated testing center at no additional cost to the applicant. IAHCSMM’s “Americans with Disabilities Policy Statement” can be found in full at IAHCSMM.org and in the Certification Handbook. If you believe that you qualify for an accommodation pursuant to the ADA, we ask that you contact IAHCSMM to request a Special Accommodations form, to be completed and submitted with your application.