PROFESSIONAL ASSOCIATION OF
HEALTH CARE OFFICE MANAGEMENT

CONTINUING EDUCATION UNIT (CEU) DOCUMENTATION FORM

Full Name:______________________________ PAHCOM Member#______________
Organization:______________________________ Membership Renewal Date______________
Address: ______________________________ CMM Recertification Due:______________
City/State/Zip______________________________
Business Phone:______________________________ Fax:______________

IMPORTANT INFORMATION - PLEASE READ

Registration is required every two years
The following requirements must be met for recertification of your CMM status:

1. Documentation of 24 CEUs - Certify attainment by completing this form and signing below.
2. Continuous active PAHCOM membership.
3. Recertification fee.

EDUCATIONAL SESSIONS ATTENDED

PROGRAM/SESSION:______________________________
DATE(s) ATTENDED:__________ TYPE of PROGRAM: ______________ CEUs__________

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PROGRAM/SESSION:______________________________
DATE(s) ATTENDED:__________ TYPE of PROGRAM: ______________ CEUs__________

I certify upon penalty of decertification that I attended all of the above cited educational sessions and qualify for certification renewal.

Date:______________ Signature:______________________________

CMM RECERTIFICATION INVOICE

Note: (CMM recertification fees are tax deductible as a necessary business expense)

CMM Recertification Fee.........[ ]

☐ Check (Make payable to PAHCOM) ☐ Credit Card ☐ InHealth Vouchers

Credit Card#__ __ __ __/__ __ __ __/__ __ __ __/__ __ __ __ Exp Date: __ __/__ __
Holders Name:______________________________
Address for Card ______________________________