edac™

from The Center for Health Design

Please complete, sign, and date the application form and return it with your application fee.

Candidate Checklist

Please verify you have the information below before submitting the application.

☐ Current demographic information

☐ Candidate attestation signature

☐ Payment (including late fee, if applicable)

Candidate Demographics

Enter your name EXACTLY as it appears on your current government-issued photo ID.

Title (Mr., Miss, Mrs., etc.): _____ Last Name: _____ First Name: _____

Middle Name: _____ Suffix (II, Jr., etc.): _____ Maiden/Previous Last Name: _____

Date of Birth: ____/____ /_____ Gender: Male ☐ Female ☐
(mm/dd/yyyy)

Primary Email: _____
Note: This email address will be used as your login username for the online registration system.

Please choose a password for your account (at least 5 alphanumeric characters): _____
Note: Record this password as you will need it to log in to the EDAC registration system. Passwords are case-sensitive.

Contact Information

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Country: _____ Postal Code: _____

Telephone (Work): _____ (Home): _____ (Cell): _____

CHD Status
Please select all that apply.

☐ Corporate Affiliate	☐ Student	☐ Educational Partner	☐ Staff
☐ Professional Affiliate	☐ Champion Firm	☐ Pebble Partner	☐ Volunteer
☐ Individual Affiliate	☐ Advocate Firm	☐ Pebble Pioneer	☐ Board Member

Education
Please provide education information for the highest level you have completed. Educational information is optional.

Institution Name: _____ City: _____ State/Province: _____

Country: _____ Degree Title: _____ Major/Concentration: _____

Type of Degree (circle): AA AS BA BS MBA MA MS PhD MD JD

Date of Degree: ☐☐/☐☐☐☐ Attended From: ☐☐/☐☐☐☐ Until: ☐☐/☐☐☐☐

Current Employment Information
Please select the best description of your occupation.

☐ Architect	☐ Educator	☐ Researcher	☐ Product Manufacturer
☐ Interior Designer	☐ Student	☐ Healthcare Practitioner	☐ Consultant
☐ Construction Professional	☐ Healthcare Administrator/Manager	☐ Healthcare Facility Manager	☐ Other

*Please provide **current** employment information.*

Employer: _____ Job Title: _____

Street: _____ City: _____ State: _____

Start Date: _____/_____
(mm/yyyy)

Previous Employment Information
*Please provide **previous** employment information. Attach additional pages as needed.*

#1
Employer: _____ Job Title: _____

Street: _____ City: _____ State: _____

Start Date: _____/_____ End Date: _____/_____
(mm/yyyy) *(mm/yyyy)*

Registry

I understand that the Center for Health Design (CHD) will maintain a registry of certified individuals that will be accessible to the general public via an EDAC-sponsored Web site. I agree to participate in such a registry using my name, city, and state as they appear in the identification information section of my application. I understand that I may modify or remove myself from the registry at any time.

☐ No, I do not wish to be included.

☐ Yes, I wish to be included. Please include my name, city, state, and occupation as they appear in the demographics section of this application. In addition, please include the following contact information. *(Select all that apply.)*

☐ Company/employer as it appears on this application	☐ Email address as it appears on this application	☐ Work telephone number as it appears on this application

Candidate Attestation

Please read and sign the statement below.

I hereby solemnly declare and affirm, under penalties of perjury that the facts and matters contained in the following foregoing application are true and correct.

☐ I agree with the above statement.

Applicant Signature:_____ Date: _____

Payment

If you have a discount code, enter it here: _____

The CHD EDAC examination is $395. If you have entered a discount code above, please calculate the new total before filling out the payment information below.

☐ I have ***not*** completed an online application. I authorize payment of the application fee ($395 minus discount, if applicable) plus a $50 late application/scheduling fee.

☐ I ***have*** completed an online application; however, I did not complete online test scheduling before the deadline (4 days prior to the test date). I authorize payment of a $50 late scheduling fee.

_____

Please choose your payment method below:

☐ Cashier's check/money order payment enclosed: $_____
(Payable in U.S. funds to Scantron)

OR

☐ Credit Card Payment
(Provide credit card information on the next page.)

☐ MasterCard ☐ Visa ☐ American Express

Authorized Name on Card: _____ Amount to be Paid: $_____

Credit Card Account Number: _____ Expiration Date: (_____/_____)
(mm/yyyy)

Card ID Number: _____ Authorized Card Holder's Signature: _____

Candidate Name (if different from above): _____

Billing Address

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Postal Code: _____

Telephone: _____

Please submit all application materials to:
Scantron
Attention: CHD EDAC Exam
P.O. Box 570
Morrisville, NC 27560 USA