THE AMERICAN INSTITUTE OF HEALTH CARE PROFESSIONALS, INC.

SPIRITUAL COUNSELING

APPLICATION FOR CERTIFICATION

Name:_____ Date:_____

Mailing Address:_____

City:_____ State:_____Zip:_____

Phone:_____ Fax: _____

Email Address:_____

School or Educational Program Attended for Spiritual Counseling:

_____

Date of Completion:_____ Number of hours of instruction:_____

Applicants must submit one of the following: 1) a copy of their certificate of completion, or 2) an official letter by the school, educational program, or instructor verifying successful completion of the program and the number of contact hours of the educational program. Note: if the certificate of completion does not have the number of contact hours detailed on it, then it is necessary to submit an official letter from the school, program or instructor verifying the number of hours or college credits earned.

For translation purposes, the AIHCP uses the following conversion: 50 minutes = 1 contact hour. 1 semester unit of college credit = 15 contact hours.

For Applicants Applying with Education Hours from various courses, seminars, etc.

Applicants must submit to the American Institute of Health Care Professionals, Inc., photocopies of all education certificates or transcripts, verifying attendance and completion of the educational programs, seminars, courses, etc. The AIHCP reserves the right to contact any providers of such programs and verify completion/attendance by the applicant.

For Applicants applying for Certification by Evidence of University/College Degree and Education Hours: University/College that granted the Degree:

State:_____ City:_____

Degree Granted:_____

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Date Degree was Conferred:

_____

Candidates must have the University or College send an official transcript directly to the AIHCP. Photocopies of University/College transcripts are not acceptable. Have transcripts sent to: The American Institute of Health Care Professionals, Inc, 2400 Niles-Cortland Rd. S.E. Warren, Ohio 44484

Method of Payment- Application fee for 3 year term of certification is $ 150.00

Checks and money orders are payable to: AIHCP

_____ Check

_____ Money Order

_____ Credit Card _____ Visa _____ MC ___ American Exp

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 certification. 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 have provided fraudulent documentation to the AIHCP that the AIHCP may rescind my certification.

Agreed:

_____ Date:_____

Signature