Certified Joint Commission Professional (CJCP™)
EXAMINATION APPLICATION

You must complete all sections of this form. Please include credit card information or enclose a cashier’s check or money order payable to PSI Services Inc. for the appropriate amount. Mail the application and fee to:

CJCP Examination, PSI, 18000 W. 105th St., Olathe, KS 66061-7543.
For further information, you may call Candidate Services at 888-519-9901.

PERSONAL INFORMATION (please print using black or blue ink)

Name: ___________________________________________________________________________________________________________
(Last, First, Middle)
Date of Birth: ________________________________
Daytime Telephone Number: ______________________________ Cell Phone Number: _____________________________________
Fax Number: ________________________________ Email Address: ______________________________________________________
Street Address: ___________________________________________________________________________________________________
_________________________________________________________________________________________________________________
City: ____________________________________________________ State: ___________________________________________________
Zip Code/Postal Code: ___________________________________ Country: ________________________________________________

ELIGIBILITY REQUIREMENTS – Please indicate which of the following eligibility requirements qualifies you for the examination:

☐ Bachelor’s degree or higher with current employment at a hospital, organization, system level for at least two (2) years in an accreditation preparation, assistance, coordination, management, or maintenance role.

☐ Bachelor’s degree or higher with current employment at a hospital, organization, system level with less than two (2) years in an accreditation preparation, assistance, coordination, management, or maintenance role. However, I do have three (3) consecutive years of previous employment in an accreditation preparation role (which could include a hospital/system, home care, ambulatory care, long term care, or behavioral health care organization.)

☐ Associate’s degree or a Registered Nurse with current employment at a hospital, organization, system level for at least five (5) years experience in an accreditation preparation, assistance, coordination, management, or maintenance role.

☐ Associate’s degree or a Registered Nurse with current employment at a hospital, organization, system level with less than five (5) years in an accreditation preparation, assistance, coordination, management, or maintenance role. However, I do have four (4) consecutive years of previous employment in an accreditation preparation role (which could include a hospital/system, home care, ambulatory care, long term care, or behavioral health care organization.)

☐ I have been approved by JCR to qualify for the examination by waiver.

EXAMINATION INFORMATION

I am including a Special Accommodations Request:

☐ No
☐ Yes (Complete the form included in this handbook.)

I am a: ☐ New Applicant ☐ Reapplicant ☐ Recertifier

EXAMINATION FEE

Payment of the $375 examination fee may be made by credit card, cashier’s check or money order payable to PSI Services Inc.

If payment is made by credit card, complete the following:

☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

I agree to pay the amount indicated according to card issuer agreement.

Credit Card Number __________________________ Expiration Date ________________
Name on Card __________________________
Signature __________________________
EMPLOYMENT INFORMATION

Title at CURRENT place of employment: __________________________________________________________

Organization: ________________________________________________________________________________

Address: ____________________________________________________________________________________

State, Zip: __________________________ Dates of Employment: _________________________________

Telephone of Organization: ______________________________ Contact for Verification: __________________

Title at PREVIOUS place of employment: __________________________________________________________

Organization: ________________________________________________________________________________

Address: ____________________________________________________________________________________

State, Zip: __________________________ Dates of Employment: _________________________________

Telephone of Organization: ______________________________ Contact for Verification: __________________

DEMOGRAPHIC QUESTIONS

1. Highest Education Level Achieved:
   - Diploma in Nursing (Registered Nurse)
   - Associate’s Degree
   - Bachelor’s Degree
   - Master’s Degree
   - Medical Degree (MD, DO)
   - Doctoral Degree (other than medical doctor)

2. Years of experience in healthcare quality, Joint Commission accreditation preparation, coordination, assistance, management, or maintenance:
   - 2 years
   - 3-5 years
   - 6-9 years
   - 10-15 years
   - 16-19 years
   - More than 20 years

3. Choose the title that best describes you:
   - Director of Quality/PI
   - Accreditation Coordinator
   - Risk Manager
   - Patient Safety Officer
   - Pharmacist
   - Consultant
   - Chief Nursing Officer
   - Nurse Manager
   - Chief Medical Officer
   - Physician
   - Life Safety Code Specialist
   - Administrator
   - Compliance Officer
   - Director of Engineering/Maintenance
   - Facilities Manager
   - Medical Staff Services Professional
   - JCR or Joint Commission Employee

SIGNATURE

By passing the exam, I give permission to JCR and The Joint Commission to publish my name on their website or within social media.

I understand that JCR will be doing telephone interviews of CJCP Candidates as part of the application process and that I may be called for such interview.

I understand that the following accompanying materials must be received prior to my application being deemed complete:
   - copy of my current job description

Should I pass the exam, I understand that my application fee includes a formal certificate. The formal certificate will be mailed to the address listed on this application form.

Sign and date in ink.

Name (Please Print): __________________________________________________________

Signature: ________________________________ Date: __________________________