Certified Health Care Professionals Association

Website: http://www.chcpa.org/ Email：student_registration@chcpa.org

Examination Docket Application

Application Requirements and Additional Information

1. Education

1) You must have completed a baccalaureate degree equivalent or higher majored in medical or nursing.

2) You must have finished the educational assessment required from the association and submit the notification with the “Examination Docket Application” form to us by person or by email showed on the application form.

3) Transcripts must be sent from your college or university directly to the association.

2. Language requirement

You must meet the language requirement of each certificate of CHCPA. For details, please contact the association at: student_registration@chcpa.org or ippc@chcpa.org

3. Application Fees

First Time Application: $120

Re-application: $60

4. Other documents

The form must be completed, signed and sent to the association with all the documents required as follows:

1) Notification of educational assessment;

2) Passport photo;

3) Passport soft copy;

5. Contact Preference for Notification

ALL notifications or correspondence will be sent to you by the Contact Method Preference you indicate on your application (e.g., if you select email, ALL notifications or correspondence will be sent to your email address)

6. Address or Name Change

Any name, address or email change MUST be reported to the Association promptly. Failure to do so will result in your not receiving notices of scores and other official correspondence. Please email us for any change of your contact information.

Please contact us with any questions you may have via email: ippc@chcpa.org.

Please also visit these other websites that may be of assistance: http://www.chcpa.org/ .

CHCPA
Certified Health Care Professional Association

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You are: ◉ First Time Applicant ○ Re-application

APPLICANT LEGAL NAME (Name must EXACTLY MATCH your passport , otherwise your application will be invalid.)

FIRST NAME MIDDLE NAME LAST NAME

Passport ID BIRTH DATE

PERSONAL ADDRESS:

STATE/PROVINCE CITY/COUNTY

COUNTRY POSTAL CODE

TELEPHONE EMAIL

Contact Preference: ☐ EMAIL ☐ POSTAL ☐ TELEPHONE

EXAM APPLY FOR:

- ◉ Certified Professional Medical Practitioner
- ○ Certified Health Care Practitioner
- ○ Certified International Physician Assistant
- ○ Heart Saver First Aid CPR AED
- ○ Certified Advanced Health Care Practitioner
- ○ Certified Oriental Medical Practitioner
- ○ International Physician Proficiency Cetification

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Examination Docket Application

EXAM DATE

	Exam Date			
	March 30, 2026	June 29, 2026	September 28, 2026	December 28, 2026
Certified Professional Medical Practitioner				
Certified Health Care Practitioner				
Certified International Physician Assistant				
Heart Saver First Aid CPR AED				
CertifiedAdvanced Health Care Practitioner				
Certified Oriental Medical Practitioner				
International Physician Proficiency Cetification				

Please put "√" in the form to the date that you want to take the exam. False to do so will make the exam schedule invalid and the application fees are not refundable. Please note that if it is full for the exam seats in each exam date, your application will be extended to the next test window.

STATEMENTS

☐ I certify to the truth and accuracy of all information, answers and representations in this application.

☐ I agree to keep it confidential and I shall not divulge the contents of the CHCPA examination in any form. I shall not violate the provisions of the examination or any regulations of the CHCPA.Otherwise CHCPA has the right to disqualify the qualification of attending the examination once violating the relevant regulations.

☐ I agree that any breach of these terms may cause my being automatically disqualified, or expelled, from the examination.

Print Full Legal Name: Date:

Signature:

OFFICE USE ONLY:

Receipt #:	Date: