



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.)*

<input type="checkbox"/> Company/employer as it appears on this application	<input type="checkbox"/> Email address as it appears on this application	<input type="checkbox"/> Work telephone number as it appears on this application
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**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 (30 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 Castle Worldwide, Inc.)*

**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:  
Castle Worldwide, Inc  
Attention: CHD EDAC Exam  
P.O. Box 570  
Morrisville, NC 27560 USA**