



Association for Healthcare Documentation Integrity  
 4230 Kiernan Ave. Suite #130  
 800-982-2182, [www.ahdionline.org](http://www.ahdionline.org), [edapproval@ahdionline.org](mailto:edapproval@ahdionline.org)

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## PEER REVIEWER APPLICATION

### Contact Information

Name/Credentials: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

AHDI Member Number: \_\_\_\_\_ CMT Number: \_\_\_\_\_

### Current Employment

Employer: \_\_\_\_\_

Position Title: \_\_\_\_\_ Years Employed: \_\_\_\_\_

### Past Employment

Employer: \_\_\_\_\_

Position Title: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Employer: \_\_\_\_\_

Position Title: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Employer: \_\_\_\_\_

Position Title: \_\_\_\_\_ Years Employed: \_\_\_\_\_

### Education Program Affiliation

Yes No (Circle one)

Do you, or have you ever had a relationship (employment, consultant, advisor, etc) with any medical transcription education program. If yes, please provide list on a separate sheet of paper and attach to application.

*Continued on Next Page*

**Academic Degrees**

Doctorate     Masters     Baccalaureate     None     Other: \_\_\_\_\_

**Accreditation/Approval Process Experience**

Organization: \_\_\_\_\_

Position Title: \_\_\_\_\_ Years of Service: \_\_\_\_\_

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Position Title: \_\_\_\_\_ Years of Service: \_\_\_\_\_

**Professional Association Service** (*attach separate list if necessary*)

Association: \_\_\_\_\_

Position Served: \_\_\_\_\_ Years: \_\_\_\_\_  National  Local/State

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**Purpose Statement** (*state here or attach separate sheet*)

**Attachment Checklist**

- Curriculum Vitae
- Two Letters of Recommendation
- Purpose Statement

**Return To**

AHDI Education Approval Department  
4230 Kiernan Ave. Suite #130  
Phone: 800-982-2182, Fax: 209-527-9633