



APPLICATION FOR CERTIFICATION PORTFOLIO EXAMINATION  
FOR HEALTH PROFESSIONAL LIFE CARE PLANNERS (CHLCP™)

### Application Directions

Please read the Handbook for Candidates carefully before completing this application. When filling out the application, please enter all requested information in the spaces provided. Please include all supporting documentation with your application. Be sure to save your application before submitting it, with your supporting documentation, to the Universal Life Care Planner Certification Board (ULCPCB™).

Please note, Candidates applying under Option 2 must provide verification indicative of two (2) years full time, paid, professional work experience in the field of life care planning or a variant thereof as outlined in the Handbook. A completed Verification of Work Experience form must be included with supporting documentation and can be located [here](#).

\*Indicates a mandatory response

### Candidate Information

**Please enter your name exactly as it appears on your current Government-issues photo I.D.**

Title (e.g., Ms., Mrs., Mr. Dr., etc.) \_\_\_\_\_  
First Name\* \_\_\_\_\_  
Middle Name \_\_\_\_\_  
Last Name\* \_\_\_\_\_

### Contact Information

#### Email Address

Please enter a valid email address. Please add [shirley@daugherty-legalnurse.com](mailto:shirley@daugherty-legalnurse.com) and [secretary@ulcpcb.org](mailto:secretary@ulcpcb.org) to the safe domain list of your email to ensure that emails from the ULCPCB™ are received.

Email Address\* \_\_\_\_\_

Confirm your Email Address\* \_\_\_\_\_

#### Home Address

Street\* \_\_\_\_\_ Apt/Suite \_\_\_\_\_  
City\* \_\_\_\_\_  
Country\* \_\_\_\_\_  
State\* \_\_\_\_\_  
Zip Code\* \_\_\_\_\_

**Work Address (optional)**

Street \_\_\_\_\_ Apt/Suite \_\_\_\_\_  
City \_\_\_\_\_  
Country \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_

**Phone Numbers**

Provide at least one phone number\*

Work Number (with area code): \_\_\_\_\_  
Home Number (with area code): \_\_\_\_\_  
Cell Number (with area code): \_\_\_\_\_

**Phone Preference**

Please select your preferred phone for communications.

- Home/Cell
- Work

**Address Preference**

Please select your preferred address for communications.

*(Your individual score report of examination will be sent to your home address only)*

- Home
- Work/Business

**Request for Test Accommodations**

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**Are you requesting test accommodations and have a disability covered by the Americans with Disabilities Act?**

- Yes
- No

**Examination and Certification Information**

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**Have you taken this exam before? \***

- Yes
- No

**If yes\*, when did you take the exam? \_\_\_\_\_**  
MM/YYYY

**Are you currently, or have you ever been certified as a CHLCP™? \***

- No
- Yes, currently certified
- Yes, previously certified but certification lapsed; apply for re-certification

**When does/did your certification expire? \***

\_\_\_\_\_ Non-applicable \_\_\_\_\_  
MM/DD/YYYY

**What is your most recent certification number?**

**(only\* if you are applying to recertify your CHLCP™ credential)**

# \_\_\_\_\_

### Professional Healthcare Licensure

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**Do you have a current, unrestricted healthcare license that has been valid a minimum of two years? \***

- Yes  
 No

*A Candidate must have an unrestricted healthcare license that has been valid a minimum of two years.*

**Type of License\***

- Medical/Osteopathic Doctor  
 Nurse Practitioner  
 Occupational Therapist  
 Physical Therapist  
 Psychologist/Neuropsychologist  
 Registered Nurse  
 Speech Therapist  
 Chiropractor  
 Licensed Social Worker

**Professional healthcare license number\*** \_\_\_\_\_

**State where licensed\*** \_\_\_\_\_

**License issue year\*** \_\_\_\_\_

**License expiration date\*** \_\_\_\_\_  
MM/DD/YYYY

## Eligibility and Background Information

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All responses are required except where indicated.

### Education/Skills\*

(Choose one option)

- Option 1 (120 hours of continuing education units as outlined in the Handbook)
- Option 2 (2 years/4000 hours paid or billable life care planning experience as outlined in the Handbook)

### Experience in Case Management\*

- 0-2 years
- 3 years
- 4 to 5 years
- 6 to 7 years
- 8 to 9 years
- 10 or more years

### Experience in Life Care Planning\*

- 0-2 years
- 3 years
- 4 to 5 years
- 6 to 7 years
- 8 to 9 years
- 10 or more years

### Percentage of working time currently spent in Life Care Planning\*

- 0 to 24%
- 25 to 49%
- 50 to 74%
- 75 to 100%

### Primary Practice Setting\*

- Independent Practice
- Insurance
- Law Firm
- Case Management Company
- Government Agency
- Managed Care Organization
- Integrated Network
- Hospital
- Other
- If you selected "Other"\*, please explain \_\_\_\_\_

**Highest academic level attained\***

- Associate Degree
- Diploma in Nursing
- Bachelor's Degree, Nursing
- Bachelor's Degree, Non-nursing
- Master's Degree, Nursing
- Master's Degree, Non-nursing
- Doctoral Degree, Nursing
- Doctoral Degree, Non-nursing

**Organizations to which you belong\***

**(Check all that apply)**

- American Academy of Physician Life Care Planners
- American Association of Legal Nurse Consultants
- American Association of Nurse Life Care Planners (AANLCP)
- American Nurses Association
- Association of Rehabilitation Nurses
- Case Management Society of America
- International Association of Rehabilitation Professionals/International Academy of Life Care Planners
- National Association of Case Managers
- National Medical Secondary Payer Network

**How did you hear about this examination? \***

**(Check all that apply)**

- Conference
- Professional Journal
- Employer
- Colleague/word of mouth
- Social media
- Internet
- Other
- If you selected "Other"\*, please explain** \_\_\_\_\_

**Are you currently a member of AANLCP? \***

**Note:** Membership in AANLCP is not required.

- No
- Yes

## Supporting Documentation

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### All of the following documents must be provided with the application

- Copy of current healthcare license
- Copy of current resume or curriculum vitae
- Candidates applying under Option 1 only:  
*Proof of 120 hours of continuing education as outlined in the Handbook*
- Candidates applying under Option 2 only:  
*Completed Verification of Work Experience Form*
- Completed Request for Test Accommodations Form (*if applicable*)

## Optional Information

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**Note:** Information related to race and age are optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your test results.

### Race

- Asian
- Black or African American
- Hispanic, Latino, or Spanish
- Indigenous People
- White or Caucasian
- Biracial
- Prefer not to say

### Age Range

- Under 25
- 25-29
- 30-39
- 40-49
- 50-59
- 60+
- Prefer not to say

## Candidate Statement and Signature

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*\*I have read the Handbook for Candidates and understand I am responsible for knowing its contents. I certify that the information given in the Application is in accordance with Handbook instructions and is accurate, correct, and complete. Information of a Candidate's initial certification date, renewal dates, and any CHLCP™ suspensions or revocation of CHLCP™ will be released by the Universal Life Care Planner Certification Board (ULPCB™) upon request to any public entity or agency. Verification is also available via the website tool. By signing this Application, I am providing authorization for release of this information and for the use of aggregate data. I additionally authorize the ULPCB™ to post my name, email address, date of my initial*

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*certification, and expiration date on the ULCPCB™ website for its online listing of current certified health professional life care planners. Additional personal information will not be released without my approval.*

*\*I have completed a minimum of two (2) years/4000 hours paid or billable professional healthcare experience that requires licensure and determination of Patient/Client needs within the five (5) years immediately preceding application.*

By checking here I certify all of the above statements are true.

**Please print your full legal name** \_\_\_\_\_

**Signature** \_\_\_\_\_

### Payment and Submission of Application

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Before submitting the Application, please verify the information on the form above is accurate and complete and that you are applying for the correct examination. After application has been submitted, information cannot be modified.

We are only able to accept checks at this time.

Checks should be made out to “Universal Life Care Planner Certification Board”.

Please write “CHLCP Application” in the memo line.

Portfolio Examination, Initial Certification fee is \$395.00

Retesting Fee is \$230.00

Please mail your completed application and check to:

Universal Life Care Planner Certification Board

RE: CHLCP Application

PO Box 3311

Concord, NH 03302-3311

Note that your application will be considered pending until the Universal Life Care Planner Certification Board has received your payment of the application fee.

Please print the completed Application for your records.

*Thank you for submitting your application.*

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#### FOR OFFICE USE ONLY

Date Received \_\_\_\_\_

Fee: \_\_\_\_\_