Certified Quality & Risk Management Specialist
Alliance for Long Term Care Quality Improvement

Personal Data

Name: (First, MI, Last) _____

Home Mailing Address: _____
Street

_____
City /State Zip

Email Address-Personal: _____

Phone Number Personal: _____OK to TEXT: Yes No

Email Address-Work:_____

Phone Number- Work: _____

Qualifying Experience

Current Employer:_____

Address: _____

Position: _____

Previous Employer: _____

Address: _____

Position:_____

Current Licenses:

License_____Number:_____State:_____

License_____Number:_____State:_____

License_____Number:_____State:_____

Certifications and Professional Memberships

Organization Position/Office Held Certification

_____

_____

_____

Education and Training

Circle Highest Level Attained:
Associate Degree Baccalaureate Degree Graduate Degree

College/Technical School Name/City/State Dates Attended Degree Obtained

_____
_____
_____

Professional References Outside Your Current Organization. (minimum of two)

Name Title/Organization Email Address

_____
_____
_____

Applicant Statement/Signature

I attest to the accuracy of all information submitted for certification evaluation. Upon certification, I acknowledge my responsibility for adhering to the CQRMS Code of Ethics and maintaining professional competence through continuing education.

_____ _____
Signature Date

All information contained on this CQRMS application is kept confidential. Information obtained is not shared and any other use of this information is prohibited by ALTCQI and Gallagher entities.