Certification in Clinical Documentation Improvement and Integrity
Continuing Education Form

Date _____ **DocuComp LLC ID Number** _____

First Name _____ Last Name _____

Job Title _____ Company _____

Home Address _____ Work Address _____

City _____ State ____ ZIP _____City _____ State ____ ZIP _____

Home Phone (_____) _____ Work Phone (_____) _____

E-mail Address _____

CEUs for Submission

Program Date	Program Title	Sponsoring Organization	CEU Hours

Please mail this form and copies of all documentation supporting recertification to: DocuComp LLC Healthcare, P.O. Box 10530 Jackson Mississippi 39283. Forms may also be faxed to 769-208-8613

Questions? Feel free to contact DocuComp LLC with any questions at CustomerService@docucompllc.com or 740-968-0472. **The recertification fee is $150.00.** ☐ I paid the recertification fee online.