American Council of Holistic Medicine

2840 West Bay Dr. #214
Belleair Bluffs, FL 33770
www.theachm.org
Email:theachm@gmail.com
Date: _____

Renewal Application

1. Name:_____
   Address:_____
   City: _____State_____Zip Code_____
2. Telephone Number: _____
3. Email Address:_____
4. Certificate Number_____
5. Date of Last Certification_____

Certification Level-Circle One

- ***Consultant***
- ***Diplomate***

Please note: You cannot change your original certification level or designated specialty. If you wish to do so, a new application must be submitted with appropriate fee, and an exam may be required.

Specialty Designation as it appears on Your Document:

****Cost: $79.00USD Payment can be me made by PayPal online on the *Become Certified* page or by sending a check to our address.**
****If your name has changed since original certification, you must include proof of name change.**