



## THE AMERICAN COLLEGE OF HEALTHCARE ARCHITECTS (ACHA)

PO Box 14548 Lenexa, KS 66285-4548

Phone: (913) 895-4604; Fax: (913) 895-4652

E-mail: [acha-info@goamp.com](mailto:acha-info@goamp.com) Website: [www.healtharchitects.org](http://www.healtharchitects.org)

### APPLICATION FORM

#### GENERAL INSTRUCTIONS:

Applicants are expected to satisfy *all* requirements identified on the eligibility requirements. The ACHA certification committee will review the application, references, and portfolio. If approved to sit for the examination, a letter stating that the applicant is approved as an examination candidate, examination scheduling instructions and the ACHA Examination Handbook will be mailed to the candidate.

#### Examinations:

ACHA's examination is administered in March, June and September each year. All materials submitted are required to be postmarked at least 60 days prior to the first day of the examination (December 31, March 31 or June 30) to be reviewed and approved for the next scheduled examination.

Examinations are administered Monday – Friday during morning and afternoon sessions at over 140 nationally located assessment centers. Visit [www.goAMP.com](http://www.goAMP.com) to locate an assessment center in your area.

#### Fees:

\$400 fee payable to the American College of Healthcare Architects. An additional \$50.00 will be assessed for insufficient funds. (*ACHA does not accept credit card payments*). *The fee includes:*

- \$150 Application Fee: Non-refundable, necessary for examination application.
- \$250 Examination Fee: (If an application is not deemed complete and cannot be accepted, or is withdrawn, the \$250 examination fee will be refunded).

#### Continuing Education:

Each candidate who successfully passes the examination will be awarded 20 CEUs through the American Institute of Architects (AIA). Please note your AIA number on your application if you are a member.

#### Change of Address:

The address provided on your application will be used for mailing your confirmation notice of eligibility. Please send all address changes to ACHA PO Box 14548, Lenexa, KS 66285-4548 or via e-mail to [acha-info@goamp.com](mailto:acha-info@goamp.com).

#### Mailing Instructions:

Please send application portfolios to:

by Standard Mail:

American College of Healthcare Architects (ACHA)  
PO Box 14548  
Lenexa, KS 66285-4548

by Overnight Courier:

ACHA  
18000 W. 105th St.  
Olathe, KS 66061-7543

#### Study Materials:

You may download a copy of the ACHA Candidate Handbook from the ACHA website at [www.healtharchitects.org](http://www.healtharchitects.org) or by contacting the ACHA Executive Office at [acha-info@goamp.com](mailto:acha-info@goamp.com). The handbook contains a copy of the ACHA Examination Content Outline and additional reference materials to study in preparation for the examination. The participant material from an Examination Preparation Seminar is also available on the ACHA website.

## ELIGIBILITY REQUIREMENTS:

A complete Application and Portfolio must include the following items:

- (1) Copy of your original Application and Portfolio bound in 8 ½" x 11" loose-leaf format.
- (1) CD-ROM containing all of the Application and Portfolio pages saved in an Adobe .pdf format. **Must be submitted in one .pdf file.**
  
- The application form completed in its entirety and signed by the applicant. The application form should be inserted at the beginning of the portfolio binder.
  - Passport-sized photograph autographed across front in blue ink.
  - The Applicant Consent form completed and signed by the applicant.
  
- Demonstration of practice as a licensed architect for not less than 5 years in at least one jurisdiction of the United States, its territories, or Canada. *A photocopy of the applicant's original license or licensing certificate is acceptable documentation.*
  
- A currently valid license to practice architecture in at least one jurisdiction of the United States, its possessions, or in a province of Canada. *A photocopy of the applicant's current wallet identification card is acceptable documentation.*
  
- Demonstration of a period following licensure of *at least three of the past five years in which the specialty of healthcare facility architecture represents the majority of an applicant's full-time practice.*
  
- Three (3) letters of recommendation from architects who know your work personally and who are not in the firm where you are currently employed. *Reference letters must contain specific language that indicates that the referring architect believes the applicant to be qualified for ACHA Board Certification.*
  
- Three (3) letters of reference from clients must contain specific language that indicates the applicant's specific role on the projects submitted with the portfolio. If a client is an ACHA member, the individual cannot also serve as an architect recommendation.
  
- Up to nine (9) projects from the past five years. A signature from another architect or client is required on the narrative to confirm your role and responsibility
  - Portfolios shall contain a narrative statement of no more than one page per project describing each project, summarizing the program, emphasizing the role and responsibility of the applicant on that project.
  - The one page narrative data should also include associated facts with each project, to include square footage, construction cost, completion dates, the name of the owner, all consultants, the contractor and other pertinent facts.
  - Portfolios shall include sufficient plans and other drawings to explain the project, and photographs or quality color copies of photos of the interior and exterior (except for renovations that do not impact the exterior). *The drawings and photos should not exceed three pages for any one project.* Candidates should include projects and presentation-quality project documentation that provides sufficient detail for reviewers to come to an understanding about the range and depth of the candidate's knowledge and experience as well as an appreciation of the candidate's ability to apply that experience and knowledge in the problem-solving and design process.

*The applicant shall be required to submit promptly to the Board amendments to this application for any changes to the information supplied herein.*



**American College of Healthcare Architects  
Examination Application**

**Attach** one recent passport-sized photograph of the applicant here.

**Sign photograph across front in blue ink**

**Please Type or Print**

**I. GENERAL INFORMATION**

Date \_\_\_\_\_

A. Name \_\_\_\_\_  
Last, (Maiden), First, Middle

B. AIA Member:  Yes, Member Number: \_\_\_\_\_  No Social Security Number: \_\_\_\_\_

C. Mailing Address: \_\_\_\_\_  
Company Street

\_\_\_\_\_

City State Zip Country

Telephone Number: \_\_\_\_\_ Facsimile Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

D. Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Country of Birth:  U.S.  Canada  Other \_\_\_\_\_  
Male/Female mo., day & yr. (specify)

E. Do you have, or have you ever had a restriction, condition, limitation, suspension, or revocation of a license to practice architecture in *any* state or jurisdiction of the United States or provinces of Canada?  
 .....  Yes  No

**If Yes,** you are required to submit along with your application your statement providing the details of any disciplinary action and restriction, condition, limitation, suspension, or revocation of your license, including the names of the disciplining agency or licensing board, the date thereof, the subject matter and sanctions.

F. Have you ever entered into a consent or similar agreement with a registration board in connection with a disciplinary action? .....  Yes  No

If **Yes**, you are required to submit with your application your statement providing the details of such consent/agreement including the names of the disciplining agency or licensing board, the date thereof, the subject matter and sanctions.

G. Have you ever been denied registration? .....  Yes  No

If **Yes**, you are required to submit with your application your statement providing the details of such denial including the names of the disciplining agency or licensing board, the date thereof, the subject matter and sanctions.

H. Degree: (1)  BArch (2)  MArch (3)  DArch (4)  No College  
(5)  Other \_\_\_\_\_ Date Conferred: \_\_\_\_\_  
(specify) mo., day, & yr.  
College/University: \_\_\_\_\_

I. Additional Education:

Additional University if necessary: \_\_\_\_\_  
Official Name

Country:  United States  Canada  Other: \_\_\_\_\_  
(specify)

- If you graduated from an architectural school outside the United States its provinces or Canada, you **must** submit comparable credentials from that institution.

II. QUALIFICATIONS:

A. License:

Have you held a current license to practice architecture in at least one state or jurisdiction of the United States of America, its territories, or provinces of Canada for the past five years?

Yes  No

Indicate date and state of **current** registration:

Original Date: \_\_\_\_\_ State/Province: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Indicate date and state of **original** registration:

Original Date: \_\_\_\_\_ State/Province: \_\_\_\_\_

List all additional registrations: (attach additional sheets if necessary) \_\_\_\_\_

B. Practice:

1. I am currently employed by:

- |  |   |
|--|---|
| <input type="checkbox"/> A private architectural practice  | <input type="checkbox"/> A private planning/consulting practice |
| <input type="checkbox"/> A healthcare organization         | <input type="checkbox"/> A public institution                   |
| <input type="checkbox"/> I am retired from active practice | <input type="checkbox"/> Other _____                            |

Name of firm: \_\_\_\_\_

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

Phone No. and Contact: \_\_\_\_\_

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> General Partner | <input type="checkbox"/> Corporation Director/Shareholder |
| <input type="checkbox"/> Employee        | <input type="checkbox"/> Other _____     |   |

2. I have practiced architecture as a principal.  Yes  No

*(A person practices as a principal by being (a) a registered architect and (b) the person in charge of the organization's architectural practice either alone or with other registered architects. If yes, furnish the following information. Attach additional sheets if necessary.)*

From: \_\_\_\_\_ To: \_\_\_\_\_

Name of firm: \_\_\_\_\_

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

Phone No. and Contact: \_\_\_\_\_

**III. EXPERIENCE**

**A. Employment Experience**

*(List experience chronologically, beginning with the most recent. Attach additional sheets as necessary.)*

Firm Name	Dates of Employment

**B. Experience in Healthcare:**

*(Applicants must have been a registered architect for at least the past five years during which, in at least three of those years, the specialty of healthcare facility architecture represented the majority of the applicant's full-time practice.)*

Year	Estimated Number of Relative Annual Hours in the practice of Healthcare Architecture: indicate hours per year and five year total (based upon 2080 available hours/year)		
		Total	

**C. Years of Healthcare Architecture Experience:**

How many years have you been practicing Healthcare Architecture? \_\_\_\_\_



## APPLICANT CONSENT

**After reading the following statement in its entirety, affix your signature and the date in the spaces provided.**

I, the undersigned, in connection with my application for certification by the American College of Healthcare Architects, hereby authorize the American College of Healthcare Architects, now and in the future, to request, procure, and review any information regarding my professional practice, moral standing and character, including any information related to any disciplinary action related to the practice of architecture by any state licensing board in which I have practiced architecture.

I hereby authorize the American College of Healthcare Architects, now and in the future, to request and procure such information from any individual or institution, each of which shall be absolutely immune from civil liability arising from any act, communication, report, recommendation or disclosure of any such information even where the information involved would otherwise be deemed privileged so long as any such act, communication, report, recommendation or disclosure is performed or made in good faith and without malice.

I hereby authorize the American College of Healthcare Architects to supply a copy of this consent, which has been executed by me, to any individual or institution from which it requests information relating to me.

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Name of Applicant (print or type)

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Signature of Applicant

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Date



## ACHA EXAMINATION CANDIDATE CHECKLIST FOR FILING APPLICATION

Did you remember to submit the following (*one original and one CD-Rom in a .pdf format **as one document***)? The following must be received for the application to be considered complete. Incomplete applications shall be returned to applicant minus a \$50 processing fee.

- ✓ Completed Application Form with the following attachments:
- ✓ Passport-size photograph autographed across the front in blue ink.
- ✓ AIA Number, if applicable
- ✓ Acceptable evidence of current registration as an architect in at least one jurisdiction of the United States of America and/or its territories, or a province of Canada.
- ✓ Three (3) Letters of Recommendation from licensed Architects who are not within your own firm.
- ✓ Three (3) Letters of Reference, preferably from different current healthcare clients identifying the project(s) on which you are currently providing, or have previously provided, professional architectural services.
- ✓ Project Portfolio: Required descriptions of up to nine (9) projects from the past five years. These must be signed by another architect or client.
- ✓ Check in the amount of \$400 payable to American College of Healthcare Architects (ACHA), which includes payment for the application and examination fee. (If a submission is not deemed complete and cannot be accepted, or is withdrawn, the \$250 examination fee will be refunded).

Package Labeled To:

**ACHA**  
**PO Box 14548**  
**Lenexa, KS 66285-4548**

or

**ACHA**  
**18000 W. 105th St.**  
**Olathe, KS 66061-7543**

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