

## Request for Consideration or Review

Candidate Information		Date:	
Candida	te ID		
Name _			
Compan	y Name		
	ddress		
City		State	Zip
Email ac	ddress (required)		
Office Te	ce Telephone Mobile Telephone		ne
Which	credential are you inquiring about?	□HCS-D ICD-10	□HCS-O □HCS-H □HCS-C
Reque	st type		
	check below the reason why you are contacting B and by a BMSC representative within 10 business of		
□Appe	eal		
Certification holders and candidates can request a BMSC review of decisions made or actions taken related to the following (check all that apply):			
□T∈ □C □D Des	Test administration Test results Certification status (censure, suspension, revocation) Denial of continuing education credits escription of problem/concern: (Please provide a detailed explanation of the event or action that occurred and my you want BMSC to review).		
*NC	OTE: ONLY the four above topics will be re	eviewed for an Ap	ppeal.
□Exter	nsion to complete continuing education re	equirements for r	ecertifications (Check all that apply):
outa			
from eme the	ledical or Personal Emergency: A medical or person completing the recertification requirements for nergency may apply to you or one of your immedia Family Medical Leave Act. Documentation (i.e. docould not complete the recertification requirement	naintaining your cred te family members; s octor's note, emerger	ential(s). A medical or personal pouse, child, or parent as defined by
	te: If the certification holder has met one of the all ification eligibility period, and is approved the exte		
	First Approved Request for an Extension - \$75 ( Second and Final Approved Request for an Extension will be authorized.		or an additional 30 days). No additional
For guid	elines, requirements, and remedies available to yok.	ou for the above topi	ics, please see the BMSC Candidate