Certified Professional Healthcare Professional (CPHQ)

Certification Reimbursement

WAHQ Member Name: ________________________________

Address: ____

Email: ____

Phone number: ____

Congratulations! A check for $75 will be mailed to you.

Please mail this form and a copy of the CPHQ certification to:

Tim Kamps
360 W. Washington Avenue, #P110
Madison, WI 53703