

OHIO HEALTH INFORMATION MANAGEMENT ASSOCIATION

NEW GRADUATE AWARD SELECTION FORM

Name of Academic Institution: \_\_\_\_\_

Program: \_\_\_\_\_ HIA \_\_\_\_\_ HIT Academic Year: \_\_\_\_\_

Name of Program Chair: \_\_\_\_\_

Name of Award Recipient: \_\_\_\_\_

*I certify that the award recipient meets all the criteria established by OHIMA for the New Graduate Award and agrees to take the AHIMA certification examination within 6 months of their graduation from the academic program.*

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*Signature of Program Chair*

*Date*

Name of Award Recipient: \_\_\_\_\_

AHIMA Membership Number: \_\_\_\_\_

Contact Information: *Note: Provide contact information that you can be reached at for at least 6 months following graduation.*

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

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

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

Date of Graduation: \_\_\_\_\_

Certification Examination: \_\_\_\_\_ RHIA \_\_\_\_\_ RHIT

*I agree to take the AHIMA certification examination within 6 months of graduation from my academic program. I further authorize OHIMA to publish my name, award, award amount and name of academic program on the OHIMA website, and to announce/post at OHIMA-sponsored programs.*

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*Signature of Award Recipient*

*Date*

Return completed form to: June Bronnert, RHIA, CCS, CCS-P  
Project Leader, OHIMA  
3753 Windy Knoll Drive  
Hamilton, OH 45013  
Questions? Email: [jbronnert69@fuse.net](mailto:jbronnert69@fuse.net)