Name:_____

Date:_____

Practice:_____

AAHA Accreditation Effective Date:_____

*The date in which accreditation at your practice was initiated or date at which you became employed at an AAHA accredited practice.

I hereby certify that I have been an Accredited Practice Team Member for a continuous period of at least three years immediately preceding the date of election to a position on the AAHA Board of Directors.

Signature:_____
(digital signature is acceptable)