



**AHVAP Certification Center  
CVAHP Scholarship Fund Attestation**

**TO BE COMPLETED BY ORGANIZATION SUPERVISOR**

I, \_\_\_\_\_, attest that the scholarship applicant below is an employee in good standing with our organization, \_\_\_\_\_, and our organization is unable to financial support the costs of this associate pursuing the Certified Value Analysis Healthcare Professional (CVAHP) board certification.

Supervisor Name

Supervisor Title

Signature of Supervisor

Date

**TO BE COMPLETED BY SCHOLARSHIP APPLICANT**

I, \_\_\_\_\_, understand and agree to the following scholarship criteria for the AHVAP Certification Center CVAHP Scholarship Program:

I will take the CVAHP certification examination within six (6) months of the date that my scholarship is approved.

I must complete either the complimentary online CVAHP board certification review course or attend the discounted in-person review course at the 2024 AHVAP Annual Conference.

I will repay the full scholarship to the AHVAP Certification Center within 30 days if I am unsuccessful in passing the certification examination.

Scholarship Applicant Name

Signature of Scholarship Applicant

Date