

Re-Test Application

Individuals who take but do not pass a certification examination may retest after sixty days from the date of last examination. Candidates may not test more than three times in any twelve month period. All candidates who retest must submit a retest application and meet eligibility requirements in effect when they submit the retest application. ANCC may require supporting documentation to determine eligibility. To apply, please complete this form, include payment, and mail it to:

ANCC
PO Box 8785
Silver Spring, MD 20907-8785

An administration fee of \$140 and any special fees are non-refundable.

2011 Fees:	ANA Member*:	\$220	APNA Member**:	\$240
	Discount*:	\$290	Non-member:	\$340

*Some national associations have negotiated discounted rates on certain exams. Please see the certification application for your exam on the ANCC website to determine if an association you belong to has negotiated a discounted rate.

Please attach a copy of your membership card if you are claiming a discount.

**APNA discounts apply only to psychiatric/mental health exams.

1. GENERAL INFORMATION

Use your legal name on the application. This name must match photo identification used for examination entry and will be the name printed on your certificate.

_____ Last Name	_____ First Name	_____ MI
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Social Security Number

_____ Exam Name	_____ Eligibility Notice/Authorization to Test Number (if known)
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Home Address

_____ City	_____ State	_____ Zip/Postal	_____ Country
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_____ Home Phone	_____ Home Fax	_____ Personal E-Mail
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2. PAYMENT

Personal Check/Money Order (payable to ANCC) Amount Enclosed: _____

Charge Card (MasterCard or VISA only) Amount to be charged: _____

Check here if this is an ATM/Debit card. See authorization below.* Promotional Code (if applicable): _____

Account Number _____ Exp. Date _____

Print Name on Card _____ Signature _____

**ATM/Debit Card users only:* I understand and agree that, by using an ATM/Debit card, I am authorizing ANCC to debit my account for the amount specified above. Further, I understand and agree that, if the ATM/Debit transaction fails or is declined, I am authorizing ANCC to complete the transaction as a credit card charge, if possible.

3. LICENSURE INFORMATION All candidates must complete this section in its entirety.

Required attachment: Attach a copy of license Check this box if your state does not issue a paper license

Current RN License Number _____

State _____ Expiration Date (month/date/year) _____

4. SPECIAL ACCOMMODATIONS/AMERICANS WITH DISABILITIES ACT



Check here if you have a disability as defined by the Americans with Disabilities Act (ADA) and require a special accommodation. Please call 1.800.284.2378 for instructions or visit www.nursecredentialing.org

5. STATEMENT OF UNDERSTANDING

I hereby apply for certification offered by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for certification. I understand that I am subject to all eligibility requirements for certification as described in this application and that eligibility for certification depends on successfully completing specified certification program requirements. If certified, my name will be included in the official listing of certified nurses.

By signing below, I authorize ANCC staff and the Commission on Certification to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to verify my credentials, education preparation, practice, professional standing, and any other information included in, submitted with, or necessary for review of this application.

I expressly acknowledge and agree that information accumulated by ANCC through the certification process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to schools or external researchers. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without my permission.

I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature, that I will maintain an active registered nurse license throughout the entire certification period, including all renewal periods. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for certification shall be sufficient cause for ANCC to: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; withhold this or other ANCC certifications; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

I further understand that if my certification record is audited, I will be required to submit documentation to support the information in my application. I further understand that if I fail to timely submit supporting documentation, ANCC can: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

(Applications received without a signature incur a delay in processing which will cause a delay in the review of your application and ability to take a certification examination.)

Required Signature _____ Print Name _____ Date _____