2013 Certification Renewal Forms

Use the forms in this handbook if you are mailing your application. See the Certification Renewal Requirements for detailed information on renewal eligibility criteria.

ANCC CERTIFICATION APPLICATION FORM

ANCC Certification Renewal

Staff use only: ☐ E ☐ P ☐ NE

PAYMENT

GENERAL INFORMATION Use your legal name on the application. This name will be printed on your certificate. If you are using renewal option B or D, this name must match photo identification used for examination entry. If your name has changed, submit copies of the legal documents supporting the name change.

Last Name | First Name | MI

Maiden or Other Past Legal Names | Social Security Number (optional)

Home Address

City | State | Zip/Postal Code | Country

Home Phone | Home Fax | Personal E-mail

Employer Name

Employer Address

City | State | Zip/Postal Code | Country

Work Phone | Work Fax | Work E-mail

☐ Personal Check/Money Order (payable to ANCC)

☐ Charge Card (MasterCard or VISA only)

☐ Check here if this is an ATM/debit card. See authorization below.*

Amount Enclosed: _____

Amount to Be Charged: _____

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.

MAILING INSTRUCTIONS Print legibly using either black or blue ink, or type. **Keep a photocopy of your application for your records.** Remember to include a copy of your membership card if you are claiming a discount. Submit this application, a copy of your RN license, and payment. If your state does not issue a paper license, you should include a printout from your state board of nursing's online verification system. Mail to:

American Nurses Credentialing Center
P.O. Box 8785
Silver Spring, MD 20907-8785

GENERAL INFORMATION • CONTINUED

Name of certification being renewed: _____

TYPE OF PRIMARY POSITION:

- ☐ Nurse Manager
- ☐ Nurse Practitioner
- ☐ Administrator/DON/CNO/VP Nursing
- ☐ Associate/Assistant Administrator
- ☐ Educator
- ☐ Researcher
- ☐ Clinical/Staff Nurse
- ☐ Clinical Nurse Specialist
- ☐ Consultant
- ☐ Other: _____

EDUCATION (CHECK ALL THAT APPLY):

- ☐ Diploma
- ☐ Associate Degree in Nursing
- ☐ Associate Degree in Other Field
- ☐ Baccalaureate in Nursing
- ☐ Baccalaureate in Other Field
- ☐ Master's in Nursing
- ☐ Master's in Other Field
- ☐ PhD in Nursing
- ☐ PhD in Other Field
- ☐ EdD
- ☐ DNP
- ☐ DNSc
- ☐ ND
- ☐ Other: _____

RENEWAL TYPE

☐ **Option A:** Professional Development plus Practice Hours if you have a current certification and the required practice hours

☐ **Option B:** Professional Development plus Testing if you have a current certification and you do not have the practice hours in your certification specialty

☐ **Option C:** Professional Development plus Practice Hours if your certification has been expired for less than 2 years

☐ **Option D:** Professional Development plus Testing if your certification has been expired for more than 2 years or you do not have practice hours in your certification specialty

SPECIAL ACCOMMODATIONS/AMERICANS WITH DISABILITIES

☐ 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/ADA.aspx**.

LICENSURE INFORMATION All candidates must complete this section in its entirety

Required attachment: Attach a copy of your license. If your state does not issue a paper license, you should include a printout from your state board of nursing's online verification system.

☐ Check this box if your RN license is not from a state or territory of the United States.

_____

Current RN License Number

_____

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

STATEMENT OF UNDERSTANDING

I hereby apply to renew my certification by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for certification renewal. I understand that I am subject to all program requirements for certification renewal as described in this application and in the General Testing and Renewal Handbook and that certification renewal depends on successfully completing specified program requirements. If my certification is renewed, my name will be included in the official listing of certified nurses. If my certification is not renewed, I understand that my name will be removed from the official listing of certified nurses and that notification may be given by ANCC to state licensing authorities or other third parties.

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, and 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 renewal 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 renewal period, including all subsequent 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 ANCC certification examinations; withhold certification renewal or other certification; 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 renewal application.)

Required Signature	Print Name	Date

MAILING LIST REFUSAL

ANCC may release mailing lists from its certification database to organizations or individuals who have information to distribute that would be beneficial to nurses or to nursing and credentialing research. If you do not wish your name and mailing address to be released for marketing purposes, please mark the decline option below.

☐ I do not wish my name and mailing address to be released for any marketing purposes.

PROFESSIONAL DEVELOPMENT RECORD

INSTRUCTIONS Before completing your Professional Development Record, read the entire application. ANCC has six unique professional development categories. Until January 1, 2014, you must fulfill two of the six categories in any combination, except doubling Category 6 or where prohibited by Unique Requirements in the Certification Renewal Requirements. For example, you could fulfill Category 1 twice, or Categories 2 and 3, or Categories 1 and 6, or Category 4 twice, or any other combination. After January 1, 2014, you must complete Category 1 plus one other category, or you may double Category 1. See Certification Renewal Requirements for detailed instructions and specific information that may be requested for audit.

Candidate's Name (Last, First, MI) Social Security Number (optional)

EQUIVALENCIES:

1 contact hour = 60 minutes
1 CEU = 10 contact hours
1 academic quarter credit = 12.5 contact hours
1 contact hour = 0.1 CEU
1 academic semester credit = 15 contact hours
1 CME = 60 minutes or 1 contact hour

CATEGORY 1 CONTINUING EDUCATION HOURS Complete 75 contact hours of continuing education credits or, if you are doubling this category, 150 continuing education hours. **Do not attach certificates of completion with this application—keep them in your files in case you are audited.** Refer to ANCC Renewal Requirements at **www.nursecredentialing.org/RenewalRequirements.aspx**. **Beginning January 1, 2014,** all advanced practice certificants (CNS and NP) are required to complete 25 continuing education hours of pharmacotherapeutics as a portion of the required 75 continuing education hours.

If any course title does not clearly reflect the course's relevance to your practice, include a brief description of how the course relates to your ANCC certification.

Title and Brief Description of Content if Title is Generic	Date MM/DD/YY	Name of Sponsor, Provider, or Institution	ANCC Approved Yes or No meets 50% criteria	Within Your Specialty Focus Yes or No meets 51% criteria	Contact Hours Awarded	Pharm Hours Awarded
				Subtotal		

Continued on the next page

Title and Brief Description of Content if Title is Generic	Date MM/DD/YY	Name of Sponsor, Provider, or Institution	ANCC Approved Yes or No meets 50% criteria	Within Your Specialty Focus Yes or No meets 51% criteria	Contact Hours Awarded	Pharm Hours Awarded
				Subtotal		
				Grand Total		

CATEGORY 2 ACADEMIC CREDITS Complete either five semester credits or six quarter credits of academic courses in your certification specialty. See Certification Renewal Requirements for specific information that may be requested for audit.

Subject/Title	Date	Name of Sponsor, Provider, or Institution	Within Your Specialty Focus Yes or No	Academic Credits

CATEGORY 3 PRESENTATIONS Present five or more different lectures related to your certification specialty that total at least 5 clock hours. You may not use lectures that are required by your job. See Certification Renewal Requirements for specific information that may be requested for audit.

Subject/Title (Must be in your specialty area)	Date	Name of Sponsor, Provider, or Institution	Clock Hours	Audience

CATEGORY 4 PUBLICATION Complete one of these four options below. See Certification Renewal Requirements for specific information that may be requested for audit. Please indicate which of the four options below you have chosen.

1. One (1) article published in a peer-reviewed journal or a book chapter related to your certification specialty. You must be the author, coauthor, editor, coeditor, or peer reviewer.
2. Five (5) different articles related to your certification specialty published in a non-peer-reviewed journal and/or newsletter.
3. Primary author of content related to your certification specialty utilized in e-learning and/or other media presentation.
4. Primary grant writer for a federal, state, or national organization project, and grant writing is not a primary component of your employment responsibilities. The purpose of the grant must be related to your certification specialty.

Subject/Title	Date	Name of Publication, Sponsor, Provider, or Institution

CATEGORY 4 RESEARCH Complete one of these four options below. See Certification Renewal Requirements for specific information that may be requested for audit. Please indicate which of the four options below you have chosen.

1. An institutional review board (IRB) research project related to your certification specialty, completed during your 5-year certification period, for which you are clearly identified as one of the primary researchers, and research is not a primary component of your employment responsibilities.
2. A completed dissertation, thesis, or graduate-level scholarly project related to your certification specialty.
3. Serve as a content reviewer on an IRB, dissertation, thesis, or scholarly project that is not a component of your employment duties.
4. Serve as a content expert reviewer of other activities related to your certification specialty and not as a part of your employment duties (such as software, e-learning, etc.). Serving as a product reviewer for your organization is not acceptable.

Subject/Title	Date	Name of Publication, Sponsor, Provider, or Institution

CATEGORY 5 PRECEPTORSHIP Complete a minimum of 120 hours of direct clinical supervision of nursing students in your certification specialty. CNSs and NPs must precept advanced practice nurses (CNS or NP) to fulfill this category. Instructions: List preceptorships below. Complete the Preceptorship Documentation Form and keep it with your records in case of audit (or obtain a signed letter from a faculty liaison that addresses everything on the Preceptorship Documentation Form). See Certification Renewal Requirements for specific information that may be requested for audit.

School Sponsoring the Preceptorship	Type of Student (CNS, NP, Undergraduate Nursing)	Dates of Preceptorship	Hours Completed
		Total	

CATEGORY 6 PROFESSIONAL SERVICE This category may not be doubled. Complete an appointment of 2 or more years of volunteer service during your certification period with an international, national, state, or local health care–related organization in which your certification specialty expertise is required. **Accepted volunteer activities include serving on boards of directors, committees, editorial boards, review boards, and task forces.** See Certification Renewal Requirements for specific information that may be requested for audit.

Organization	Type of Service	Dates of Service

DEMOGRAPHIC AND EMPLOYMENT INFORMATION

1. Location of facility:
- ☐ Urban
- ☐ Rural
- ☐ Suburban
- ☐ Outside the U.S.

2. Average number of patient encounters/visits per year at your primary place of employment:
- ☐ ≤ 1,000
- ☐ 1,001 – 5,000
- ☐ 5,001 – 10,000
- ☐ 10,001 – 20,000
- ☐ 20,001 – 40,000
- ☐ 40,001 – 60,000
- ☐ 60,001 – 80,000
- ☐ 80,001 – 100,000
- ☐ > 100,000

3. Will you receive a monetary reward/ compensation from your employer for certification?
☐ Yes ☐ No

If yes:
$ _____ per hour
$ _____ per year
$ _____ one time

4. Number of individuals you supervise:
_____

5. Years of experience as an RN (round to nearest whole year):_____

6. Total years of experience in the field in which certification is desired (round to nearest whole year):
_____

7. Primary place of employment (check one):
- ☐ Ambulatory care
- ☐ Physician-managed group practice
- ☐ Home health
- ☐ Hospice
- ☐ Hospital
- ☐ Managed care
- ☐ Nurse-managed group practice
- ☐ Nursing home
- ☐ Long-term care
- ☐ Occupational health/ environmental health
- ☐ Office nursing
- ☐ Public health/community health
- ☐ School health
- ☐ School of nursing/ university/college
- ☐ Federal/military
- ☐ Other:

_____

8. Patient population/ conditions representative of your practice (check all that apply):
- ☐ Medical-Surgical
- ☐ Cardiac
- ☐ Endocrine/Diabetes
- ☐ Pulmonary
- ☐ Neurology
- ☐ Renal/Urology
- ☐ Orthopedics
- ☐ Rehabilitation
- ☐ Gerontology
- ☐ Long-Term Care
- ☐ Perinatal
- ☐ Postpartum
- ☐ Labor and Delivery
- ☐ Pediatrics
- ☐ ER
- ☐ Trauma
- ☐ Critical Care
- ☐ Psychiatric
- ☐ Other:

_____

9. Age range of your primary patient population:
- ☐ Birth – 1
- ☐ 2 – 21
- ☐ 22 – 65
- ☐ 66+

10. Average number of hours worked per week:
- ☐ 8 or fewer
- ☐ 9 – 16
- ☐ 17 – 24
- ☐ 25 – 32
- ☐ 33 – 40
- ☐ > 40

11. Size of facility (total number of beds):
- ☐ N/A
- ☐ 1 – 100
- ☐ 101 – 250
- ☐ 251 – 500
- ☐ > 500

12. Is certification part of your employer's job performance/clinical ladder rating criteria?
☐ Yes ☐ No

13. How did you obtain this application?
- ☐ From ANCC website
- ☐ Mailed from ANCC
- ☐ From my school
- ☐ From my workplace
- ☐ At a trade show
- ☐ Other:

_____

14. Please check the professional organizations of which you are a member (check all that apply):

- ☐ AAACN American Academy of Ambulatory Care Nursing
- ☐ AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
- ☐ AANP American Association of Nurse Practitioners
- ☐ ANA American Nurses Association
- ☐ ANPD Association for Nursing Professional Development
- ☐ APHA American Public Health Association (Public Health Nursing Section)
- ☐ APNA American Psychiatric Nurses Association
- ☐ ASPMN American Society for Pain Management Nursing
- ☐ GAPNA Gerontological Advanced Practice Nurses Association
- ☐ ISPN International Society of Psychiatric-Mental Health Nurses
- ☐ NACNS National Association of Clinical Nurse Specialists
- ☐ NGNA National Gerontological Nursing Association
- ☐ PCNA Preventive Cardiovascular Nurses Association
- ☐ SVN Society for Vascular Nursing
- ☐ Other: _____

OTHER DEMOGRAPHIC INFORMATION

Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Sex: ☐ M ☐ F

Date of Birth: _____ (month/date/year)

Race/Ethnic Group
- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Other:

_____

CERTIFICATION RENEWAL CATEGORY 5: PRECEPTORSHIP DOCUMENTATION

Please do NOT submit this page with your renewal application. Keep this form with your records in case of audit.

INSTRUCTIONS

Category 5 Preceptorship: Complete a minimum of 120 hours of direct clinical supervision of nursing students in your certification specialty. CNSs and NPs must precept advanced practice nurses (CNS or NP) to fulfill this category. Keep this form with your records. You will need to submit it if you are selected for audit.

Social Security Number (optional) Last Name First Name MI

Certification Specialty

Section I Candidate Information: (Completed by faculty coordinating the preceptorship)

1. The individual named above has completed _____ hours of preceptorship for

Name of the educational institution and program (e.g., University of xxx, School of Nursing)

2. The dates for the preceptorship were _____ to _____

3. This preceptorship was conducted with students in a

☐ Clinical Nurse Specialist program ☐ Undergraduate nursing program

☐ Nurse Practitioner program ☐ Baccalaureate nursing program

☐ Other graduate nursing program (specify) _____

4. The specialty area or focus of this preceptorship was _____

5. The preceptorship was held in _____

Name of the hospital/institution/facility

Faculty coordinator name, credentials, and title (please print)

Educational institution

Program name

Institution address

Telephone number

Faculty signature Date

I hereby attest that the information provided on this form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in denial of certification or other adverse action.

Note: Please return this form to the candidate.

CERTIFICATION RENEWAL APPLICATION FEES 2013

Prices below include a $140 nonrefundable administrative fee.

ANA Member	All Certifications	$200	**Required attachment:** A copy of your American Nurses Association membership card. (Full and Direct ANA members only. Individual Affiliate members excluded from this offer.)
Collaborating Organizations	Varies—See Chart Below		**Required attachment:** A copy of your membership card.
Nonmember	All Certifications	$350	
Reactivation Fee	All Certifications	$125	Add this fee if your certification has expired.

DISCOUNT RATES FOR MEMBERS OF SPECIFIC COLLABORATING ORGANIZATIONS

To claim this discounted rate, you must have membership in an organization listed next to your certification. Required attachment: A copy of your membership card.

Certification Name	Organization	Discount Rate for 2013
Acute Care NP	American Association of Nurse Practitioners	$280
Adult-Gerontology Acute Care NP	American Association of Nurse Practitioners	$280
	Gerontological Advanced Practice Nurses Association	$280
	National Gerontological Nursing Association	$280
Adult-Gerontology Primary Care NP	American Association of Nurse Practitioners	$280
	Gerontological Advanced Practice Nurses Association	$280
	National Gerontological Nursing Association	$280
Adult Health CNS	National Association of Clinical Nurse Specialists	$280
Adult NP	American Association of Nurse Practitioners	$280
Adult Psych–Mental Health CNS	American Psychiatric Nurses Association	$240
	International Society of Psychiatric-Mental Health Nurses	$280
	National Association of Clinical Nurse Specialists	$280
Adult Psych–Mental Health NP	American Association of Nurse Practitioners	$280
	American Psychiatric Nurses Association	$240
	International Society of Psychiatric-Mental Health Nurses	$280
Ambulatory Care Nursing	American Academy of Ambulatory Care Nursing	$280
Cardiac Vascular Nursing	American Association of Cardiovascular and Pulmonary Rehabilitation	$280
	Preventive Cardiovascular Nurses Association	$280
	Society for Vascular Nursing	$280

Continued >

APPLICATION FEES 2013 CONTINUED

Certification Name	Organization	Discount Rate for 2013
Child/Adol Psych–Mental Health CNS	American Psychiatric Nurses Association	$240
	International Society of Psychiatric-Mental Health Nurses	$280
	National Association of Clinical Nurse Specialists	$280
Family NP	American Association of Nurse Practitioners	$280
Family Psych–Mental Health NP	American Association of Nurse Practitioners	$280
	American Psychiatric Nurses Association	$240
	International Society of Psychiatric-Mental Health Nurses	$280
Gerontological NP	American Association of Nurse Practitioners	$280
	Gerontological Advanced Practice Nurses Association	$280
	National Gerontological Nursing Association	$280
Gerontological Nursing	National Gerontological Nursing Association	$280
Gerontology CNS	Gerontological Advanced Practice Nurses Association	$280
	National Association of Clinical Nurse Specialists	$280
	National Gerontological Nursing Association	$280
Informatics Nursing	None available	
Medical-Surgical Nursing	None available	
Nurse Executive	None available	
Nurse Executive, Advanced	None available	
Nursing Case Management	None available	
Nursing Professional Development	Association for Nursing Professional Development	$280
Pain Management	American Society for Pain Management Nursing	$280
Pediatric NP	American Association of Nurse Practitioners	$280
Pediatric Nursing	None available	
Pediatrics CNS	National Association of Clinical Nurse Specialists	$280
Psychiatric–Mental Health Nursing	American Psychiatric Nurses Association	$240
	International Society of Psychiatric-Mental Health Nurses	$280
Public Health Nursing, Advanced	American Public Health Association-Public Health Nursing Section	$280
	National Association of Clinical Nurse Specialists	$280

Continued >

APPLICATION FEES 2013 CONTINUED

These certification exams are retired but can be renewed if professional development and practice hour requirements have been met. Testing is not an option for these certification renewals. Collaborator organization discounts are listed below.

Certification Name	Organization	Discount Rate for 2013
Cardiac Rehabilitation Nursing	None available	
Certified Vascular Nursing	None available	
CNS Core	National Association of Clinical Nurse Specialists	$280
College Health Nursing	American College Health Association	$280
General Nursing Practice	None available	
High-Risk Perinatal Nursing	None available	
Home Health Nursing	None available	
Home Health Nursing CNS	National Association of Clinical Nurse Specialists	$280
Maternal-Child Nursing	None available	
Perinatal Nursing	None available	
Public/Community Health Nursing	American Public Health Association-Public Health Nursing Section	$280
School NP	American Association of Nurse Practitioners	$280
School Nursing	None available	

FUTURE EXAM RETIREMENTS

CERTIFICATION NAME	RETIREMENT DATE
Acute Care NP	December 31, 2014
Adult Health CNS	December 31, 2014
Adult NP	December 31, 2014
Adult Psychiatric–Mental Health CNS	December 31, 2014
Adult Psychiatric–Mental Health NP	December 31, 2014
Advanced Public Health Nursing*	December 31, 2013
Child/Adolescent Psychiatric–Mental Health CNS	December 31, 2014
Gerontological CNS	December 31, 2013
Gerontological NP	December 31, 2014

*The Advanced Public Health Nursing exam method of certification will be replaced with a portfolio method of certification after December 31, 2013.