



**ANCC proudly offers certification for**

# Family Psychiatric & Mental Health Nurse Practitioner

The Family Psychiatric & Mental Health Nurse Practitioner (FPMHNP) is a registered nurse prepared in a graduate level family psychiatric & mental health nurse practitioner program to provide primary mental health care at an advanced level to individuals of all ages and families. The FPMHNP practice includes independent and interdependent decision making, and is directly accountable for clinical judgments. The graduate level preparation expands the FPMHNP's role to include differential diagnosis and management of psychiatric & mental health disorders, medication management, psychotherapeutic interventions, participation in and use of research, development and implementation of health policy, leadership, education, case management, and consultation.

### *eligibility criteria*

- > Hold a current, active RN license in a state or territory of the United States or the professional, legally recognized equivalent in another country
- > Hold a master's, post-master's, or doctorate from a family psychiatric & mental health nurse practitioner program accredited by the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC). A minimum of 500 faculty supervised clinical hours must be included in your nurse practitioner program. The FPMHNP graduate program must include course work across the life span in:
  - > advanced health assessment
  - > advanced pharmacology
  - > advanced pathophysiology
- > AND, content across the life span in
  - > health promotion and disease prevention, and
  - > differential diagnosis and disease management
- > AND, clinical training in at least two psychotherapeutic treatment modalities

**All requirements must be completed prior to application for the examination.**

**An incomplete application affects a candidate's ability to test.**

For more information: [www.nursecredentialing.org](http://www.nursecredentialing.org)



# Family Psychiatric Nurse Practitioner

**Overview of test content outline** For full test content outline, go to [www.nursecredentialing.org](http://www.nursecredentialing.org)

**I. Health Promotion and Disease Prevention as assoc with Notes 1 and/or 2**

- A. Epidemiology/risk analysis
- B. Risk reduction
- C. Health behavior guidelines
- D. Biological considerations
- E. Growth and development
- F. Screening tests
- G. Wellness assessment

**II. Assessment of Acute and Chronic Illness as assoc with Notes 1 and/or 2**

- A. Epidemiology/disease risk and control
- B. Anatomy/pathophysiology normal & abnormal
- C. Psychopathology
- D. Diagnostic reasoning/differential diagnoses
- E. Health assessment

**III. The Nurse Practitioner and Patient Relationship as assoc with Notes 1 and/or 2**

- A. Cultural competency
- B. Therapeutic communication
- C. Patient, family, and community education
- D. Promotion of patient and family wellness

**IV. Clinical Management as assoc with Note 1**

- A. Standards of practice, evidence-based practice
- B. Clinical guidelines
- C. Pharmacotherapeutics
- D. Clinical therapeutics-non-pharmacologic interventions
- E. Clinical decision-making
- F. Safety

- G. Theoretical models/applications
- H. Documentation

**V. Professional Role and Policy**

- A. Healthcare, public policy
- B. Ethics
- C. Scope of practice
- D. Access to care
- E. Coordination of services, consultation/referral
- F. Scholarly activities

**VI. Research**

- A. Research process
- B. Research utilization
- C. Continuous process improvement
- D. Outcomes evaluation
- E. Peer review: intra & inter disciplinary

**Note 1: Life Span**

- A. Aging adult: 65 years and older
- B. Adult: 18 - 64 years
- C. Adolescent: 13 - 17 years
- D. Pre-adolescent: 10 - 12 years
- E. Child: 0 - 9 years

**Note 2: Disorders per DSM IV TR**

- A. Thought disorders
- B. Affective disorders
- C. Personality disorders
- D. Substance abuse disorders
- E. Childhood disorders
- F. Other disorders

**2008-2009 Application Fees** Includes \$140 non-refundable appraisal fee

<b>ANA Member*</b>	\$270	Required attachment: A copy of your American Nurses Association membership card
<b>APNA Member</b>	\$290	Required attachment: A copy of your American Psychiatric Nurses Association membership card
<b>Discount</b>	\$340	Required attachment: A copy of your American College of Nurse Practitioners or International Society of Psychiatric-Mental Health Nurses membership card
<b>Non-Member</b>	\$390	

**Additional Special Fees:**

**International Testing** \$125 See [www.nursecredentialing.org](http://www.nursecredentialing.org) for details.

\*Full and Direct ANA members only. Individual Affiliate members excluded from this offer.

**Preparing for the Exam**

This exam is a computer-based test. This means you can apply all year and test during a 90-day window at a time and location convenient to you. Applications for this certification will be accepted at any time.

Detailed information about the application and testing process, withdrawing an application, ineligible to test, and other frequently asked questions is in the General Testing and Renewal Handbook available at [www.nursecredentialing.org](http://www.nursecredentialing.org). From this website, you can type into, save, and print your application. Please sign, attach required documents, and mail the complete application. ANCC will review it to determine whether your application meets eligibility criteria.

Information to prepare for the exam, such as review courses, detailed test content outline, references, and sample questions, is available at [www.nursecredentialing.org](http://www.nursecredentialing.org) or call our Customer Care Center at 1.800.284.2378.

If you require a verification of exam eligibility and/or certification, visit [www.nursecredentialing.org](http://www.nursecredentialing.org) or call 1.800.284.2378.

**Mailing Instructions**

Print legibly using either black or blue ink. Submit an application, copy of RN license, and payment. Remember to attach all required supporting documents and mail to:

**American Nurses Credentialing Center  
P.O. Box 791333 • Baltimore, MD 21279-1333**

**DETACH HERE**

Complete application and mail to ANCC.

## General Information

1

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

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City State Zip/Postal Country

\_\_\_\_\_  
Home Phone Home Fax Personal E-Mail

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Employer Address

\_\_\_\_\_  
City State Zip/Postal

\_\_\_\_\_  
Work Phone Work Fax Work E-Mail

### Type of primary position:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Nurse Manager                    | <input type="checkbox"/> Associate/Assistant Administrator | <input type="checkbox"/> Clinical/Staff Nurse      |
| <input type="checkbox"/> Nurse Practitioner               | <input type="checkbox"/> Educator                          | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Administrator/DON/CNO/VP Nursing | <input type="checkbox"/> Researcher                        | <input type="checkbox"/> Consultant                |
|   |  | <input type="checkbox"/> Other: _____              |

## Payment

2

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

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

Promotional Code (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Account Number Exp. Date

\_\_\_\_\_  
Print Name on Card Signature

## Special Accommodations/Americans with Disabilities Act

3



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](http://www.nursecredentialing.org)

## Validation of Nurse Practitioner Education Program

### INSTRUCTIONS

Candidate: Allow sufficient time for the program director to complete and return this form to you for inclusion with your application. Applications received without this form or with an incomplete form incur a delay that can impact your ability take the exam.

The current program director completes items 1-10 and returns the form to the candidate to include with an application. Please type or print all information.

\_\_\_\_\_  
Candidate's Name (Last, First, MI)

\_\_\_\_\_  
Social Security Number

#### 1. The individual named above graduated from:

\_\_\_\_\_  
Name of University/School

\_\_\_\_\_  
School Code  
(Available at [www.nursecredentialing.org/cert/schoolcodes.cfm](http://www.nursecredentialing.org/cert/schoolcodes.cfm))

\_\_\_\_\_  
Program Name

\_\_\_\_\_  
Program Address

\_\_\_\_\_  
Program Telephone Number

#### 2. Type of degree conferred:

- Master's nurse practitioner program
- Post-Master's nurse practitioner program  
(**Required Attachment:** Provide a detailed description of the course work and clinical hours accepted from previous graduate programs.)
- Doctorate

**3. Date program completed:** \_\_\_\_\_

**4. Date degree conferred:** \_\_\_\_\_

#### 5. Check area of concentration completed:

- Acute Care Nurse Practitioner
- Adult Nurse Practitioner
- Adult Psychiatric-Mental Health Nurse Practitioner
- Advanced Diabetes Management Nurse Practitioner
- Family Nurse Practitioner
- Family Psychiatric-Mental Health Nurse Practitioner
- Gerontological Nurse Practitioner
- Pediatric Nurse Practitioner

**10. Program Director Signature** Your signature on this form attests that the above named individual has completed the program indicated on this document.

\_\_\_\_\_  
Program Director (Print Name)

\_\_\_\_\_  
Program Director's Signature

\_\_\_\_\_  
Date

#### 6. Please indicate the title and course number of the following content:

Advanced Health Assessment \_\_\_\_\_

Pharmacology \_\_\_\_\_

Pathophysiology \_\_\_\_\_

Diagnosis and medication management of psychiatric illness (**Psychiatric and Mental Health Nurse Practitioners only**) \_\_\_\_\_

#### 7. For Psychiatric-Mental Health Nurse Practitioner Specialty Only

Please check at least two of the following the psychotherapeutic treatment modalities in which the candidate received supervised clinical training at the graduate or post graduate level:

- Individual       Group
- Family             Expressive Therapies
- Milieu              Play Therapy
- Other

**8. Total number of Didactic:** \_\_\_\_\_  
(in credit hours)

**9. Total number of Clinical:** \_\_\_\_\_  
(in clock hours)

## 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: \_\_\_\_\_

Check one of the following:

- I have requested my school send transcripts directly to ANCC.  
 I have obtained transcripts in a sealed envelope directly from my school and have attached these transcripts to this application.

Please list all degrees you have been awarded (do not include high school). Attach additional page if necessary.

**Required attachment:** All official advanced degree transcripts. The following are not accepted: photocopies, faxes, attached transcripts that are not in a sealed envelope from the school.

School Name	School Code
Major/Area of Study	Date and Degree Conferred
School Name	School Code
Major/Area of Study	Date and Degree Conferred

### School codes:

Available on-line at [www.nursecredentialing.org/certapp/schoolcodes.cfm](http://www.nursecredentialing.org/certapp/schoolcodes.cfm)

## 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)

## 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

### 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.

## 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 a registered nurse/licensed practitioner (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  
 Post-partum  
 Labor & Delivery  
 Pediatrics  
 ER  
 Trauma  
 Critical Care  
 Other: \_\_\_\_\_
9. Age range of your primary patient population:  
 0–1  
 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 tradeshow  
 Other: \_\_\_\_\_
14. Please check the professional organizations in which you are a member (check all that apply):
- |   |   |
|---|---|
| <input type="checkbox"/> AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation | <input type="checkbox"/> ANA American Nurses Association                                |
| <input type="checkbox"/> AADE American Association of Diabetes Educators                            | <input type="checkbox"/> ASPMN American Society for Pain Management Nursing             |
| <input type="checkbox"/> AAACN American Academy of Ambulatory Care Nursing                          | <input type="checkbox"/> ISPN International Society of Psychiatric-Mental Health Nurses |
| <input type="checkbox"/> ACNP American College of Nurse Practitioners                               | <input type="checkbox"/> GAPNA Gerontological Advanced Practice Nurses Association      |
| <input type="checkbox"/> ADA American Diabetes Association  | <input type="checkbox"/> NACNS National Association of Clinical Nurse Specialists       |
| <input type="checkbox"/> ADA American Dietetic Association  | <input type="checkbox"/> NGNA National Gerontological Nursing Association               |
| <input type="checkbox"/> ANI Alliance for Nursing Informatics                                       | <input type="checkbox"/> NNSDO National Nursing Staff Development Organization          |
| <input type="checkbox"/> APhA American Pharmacists Association                                      | <input type="checkbox"/> PCNA Preventive Cardiovascular Nurses Association              |
| <input type="checkbox"/> APNA American Psychiatric Nurses Association                               | <input type="checkbox"/> SVN Society for Vascular Nursing                               |
| <input type="checkbox"/> APHA American Public Health Association (Public Health Nursing Section)    | <input type="checkbox"/> 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

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Asian/Pacific Islander        | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black/African-American        | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Hispanic                      |  |

# To Do List

## Date completed:

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Read this entire application, front to back.

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Determine whether you are/when you will be eligible to take the exam.

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Complete any missing requirements such as practice hours or continuing education hours.

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Download the full length Test Content Outline and Reference List for this exam at the ANCC website: **www.nursecredentialing.org** These documents are used to create the exam.

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Download and read the General Testing and Renewal Handbook from **www.nursecredentialing.org** for a comprehensive listing of policies and critical certification candidate information.

## STUDY PLAN

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Approximately six months before you plan to take your exam, develop a study plan. This could include self study, finding a study buddy or group, taking a review course, taking an on-line narrated course, reviewing current textbooks and articles, or other methods. The key is to have a study plan and follow through with it. For ANCC exam preparation resources, refer to the back cover of this brochure.

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Review the sample test questions on the ANCC website at **www.nursecredentialing.org**

## FILL OUT THE APPLICATION

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Two to three months before you plan to take the exam, fill out the application, attaching all required documents.

**Required attachments:** (Please mail everything together in one envelope. Transcripts may be mailed separately by the university directly to the P.O. Box below.)

Photocopy of nursing license

Official transcript(s) in a sealed envelope. Transcripts may be mailed separately by the university directly to the P.O. Box.

Photocopy of membership card (if you are claiming a discount)

Payment (if you are paying by check)

## Attachments for special circumstances:

Those requesting special accommodations under the Americans with Disabilities Act (ADA) must submit a physician's letter that addresses specific required information. Please go to **www.nursecredentialing.org** or call 1.800.284.2378 for full instructions.

## MAIL APPLICATION

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Mail your application and attachments to:

**American Nurses Credentialing Center  
P.O. Box 791333  
Baltimore, MD 21279-1333**

Within two weeks from the date you mailed your application, you will receive a Receipt of Application Notice in the mail. If you do not, call 1.800.284.2378.

Within eight weeks from the date you mailed your application, you will receive either an Eligibility Notice or a letter requesting additional information. Your Eligibility Notice will give you 90 days during which to schedule and take your exam. Read it carefully and follow directions.

## RESULTS

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After you have taken your exam, you will receive results instantly at the test site. If you passed, you will receive a certificate and pin within two months. Certifications are good for 5 years.

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Request your one free verification of certification at **www.nursecredentialing.org** ANCC does not automatically send verification to your state board of nursing or employer. You must request a verification if your state board or employer requires it.

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After you pass the exam, download the Certification Renewal materials from the ANCC website at **www.nursecredentialing.org** and begin planning for your certification renewal.

# Exam Preparation Resources

## Review Seminars

Review Seminars for certification exams are available for fifteen different nursing specialties at various hospitals and schools of nursing across the country. Participants receive contact hours. Seminar schedule and registration at: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## Study Groups

Using the content from the seminars, the faculty lecture on the material during several telephone conference calls scheduled during a specific time period. Look for the "Study Group" courses in the seminar schedule. Participants receive contact hours. Study Group schedule and registration at: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## On-Line Narrated Review Courses

Our On-Line Narrated Review Courses contain the same content as our popular Review Seminars, with the voice over of an instructor talking the student through the material. After you register for the course, you will have three months in which to complete the materials. Participants receive contact hours. For more information and to register: [www.nursecredentialing.org](http://www.nursecredentialing.org)

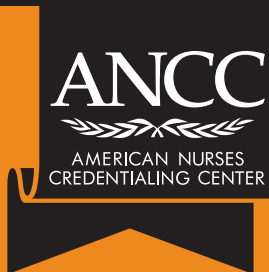
## Review and Resource Manuals

Written by nursing experts in each specialty, these manuals help candidates prepare for a variety of certification exams by enhancing your critical thinking skills and identifying strengths and weaknesses. Contact hours available on-line for an additional fee. Order manuals at: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## Certified Nurse Products

Once you have passed your exam, celebrate your accomplishment with pins, plaques, and other recognition items. [www.nursecredentialing.org](http://www.nursecredentialing.org)

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), provides individuals and organizations throughout the nursing profession with the resources they need to achieve practice excellence. ANCC's internationally renowned credentialing programs certify nurses in specialty practice areas; recognize healthcare organizations for promoting safe, healthy work environments through the Magnet Recognition Program® and the Pathway to Excellence Program™; and accredit providers of continuing nursing education. In addition, ANCC provides leading-edge information and education services and products to support its core credentialing programs. All programs of the ANCC are administered without discrimination on the basis of age, color, creed, disability, gender, health status, lifestyle, nationality, race, religion, or sexual orientation. ANA is accredited as a provider of continuing nursing education by ANCC's Commission on Accreditation. ANA is approved as a provider by the California Board of Registered Nursing, Provider number 6178.



P.O. Box 791333  
Baltimore, MD 21279-1333  
1.800.284.2378

[www.nursecredentialing.org](http://www.nursecredentialing.org)

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