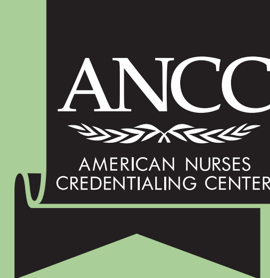


ANCC proudly offers portfolio recognition for

Advanced Forensic Nursing

eligibility criteria

Portfolio submissions must meet these minimum requirements for recognition:

- Hold a current, active RN license within a state or territory of the United States or the professional, legally recognized equivalent in another country. Graduate degree in Forensic Nursing **OR**
- Graduate degree in nursing or forensic related field and practicing in the field of forensic nursing (this option available for one five year cycle of the portfolio 2010-2014. After that time it is expected that candidates will have a degree in Forensic Nursing)

All requirements must be completed prior to application for the review date.

For more information: **www.nursecredentialing.org**

Advanced Forensic Nursing

Application Deadlines

Portfolios are reviewed every six months.

If your portfolio is submitted by:	You will receive notice by:
March 1	June 1
September 1	December 1

2009-2010 Application Fees

Includes $140 non-refundable appraisal fee

ANA* or IAFN Member	$270	Required attachment: A copy of your American Nurses Association or International Association of Forensic Nurses membership card
Non-Member	$390	

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

Contact Information

For answers to questions, visit **www.nursecredentialing.org** or call 1.800.284.2378 or email anccportfolio@ana.org.

Mailing Instructions

Please type or print legibly using either black or blue ink. Submit an application, copy of RN license, all official transcripts with degree(s) conferred, 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.

ANCC Portfolio Recognition Application

Advanced Forensic Nursing

Staff use only: ☐ E ☐ R ☐ P ☐ CC ☐ NE

FORENAP09v2 2M 09/09

General Information

1

Use your legal name on the application. This name will be the name printed on your certificate of recognition.

Last Name | First Name | MI

Maiden or Other Past Legal Names | 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:

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

Payment

2

- ☐ 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.

Education 3

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: ______________________

Please list all degrees you have been awarded (do not include high school).
Please attach additional page if necessary.
Required attachment: Transcripts from your graduate degree program. 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**

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.

Licensure Information All candidates must complete this section in its entirety. 4

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 5

I hereby apply for portfolio recognition offered by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for portfolio recognition. I understand that I am subject to all eligibility requirements for portfolio recognition as described in this application and the portfolio handbook and that eligibility for portfolio recognition depends on successfully completing specified portfolio program requirements. If portfolio recognition is granted, my name will be included in ANCC's official listing of individuals who have been awarded portfolio recognition.

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, my portfolio and any additional information submitted in support of or otherwise related to my portfolio or application for portfolio recognition.

I expressly acknowledge and agree that information accumulated by ANCC through the portfolio recognition 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, external researchers and other third parties. Otherwise, subject to my mailing list refusal rights, all information will be kept confidential and shall not be used for any other purpose without my permission.

I hereby certify that the information provided on and with this application is true, complete and accurate. I further attest, by my signature, that I will maintain an active registered nurse license throughout the entire portfolio recognition period, including all renewal periods. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for portfolio recognition shall be sufficient cause for ANCC to: bar me from current portfolio recognition and future ANCC portfolio recognition and certification; invalidate the results of my portfolio evaluation; withhold this recognition and any ANCC certification; revoke this portfolio recognition and other ANCC portfolio recognition and certification; 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 portfolio recognition record is audited, I will be required to submit documentation to support the information in my application and in my portfolio. I further understand that, if I fail to timely submit supporting documentation, ANCC can: bar me from the portfolio recognition process and future ANCC portfolio recognition and certification; invalidate the results of my portfolio evaluation; revoke this portfolio recognition and other ANCC portfolio recognition and certification; 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 portfolio documents.)

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 recognition 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 6

Please complete both sections 6 and 8 for demographic 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):

- ☐ AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
- ☐ AADE American Association of Diabetes Educators
- ☐ AAACN American Academy of Ambulatory Care Nursing
- ☐ ACNP American College of Nurse Practitioners
- ☐ ADA American Diabetes Association
- ☐ ADA American Dietetic Association
- ☐ ANI Alliance for Nursing Informatics
- ☐ APhA American Pharmacists Association
- ☐ APNA American Psychiatric Nurses Association
- ☐ APHA American Public Health Association (Public Health Nursing Section)
- ☐ ANA American Nurses Association
- ☐ ASPMN American Society for Pain Management Nursing
- ☐ IAFN International Association of Forensic Nurses
- ☐ ISPN International Society of Psychiatric-Mental Health Nurses
- ☐ GAPNA Gerontological Advanced Practice Nurses Association
- ☐ NACNS National Association of Clinical Nurse Specialists
- ☐ NGNA National Gerontological Nursing Association
- ☐ NNSDO National Nursing Staff Development Organization
- ☐ PCNA Preventive Cardiovascular Nurses Association
- ☐ SVN Society for Vascular Nursing
- ☐ Other: ______________________________

Other Demographic Information 7

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: ______________

Advanced Forensic Nursing Demographic Information 8

1. What is your focus area? (check all that apply)
   - ☐ Interpersonal Violence
   - ☐ Child Maltreatment
   - ☐ Sexual Assault
   - ☐ Domestic violence
   - ☐ Elder Abuse
   - ☐ Death Investigation
   - ☐ Corrections
   - ☐ Forensic Psych Mental Health
   - ☐ Legal Nurse Consulting
   - ☐ Emergency / Trauma services
   - ☐ Public health and Safety
   - ☐ Other: ______________________

   ____

2. Are you a member of any of the following organizations? (check all that apply)
   - ☐ American Board of Medical Legal Death Investigators
   - ☐ American Board of Forensic Examiners
   - ☐ American Academy of Forensic Sciences
   - ☐ International Association of Forensic Nurses

3. Do you work in any of these practice settings? (check all that apply)
   - ☐ DV clinics
   - ☐ Correctional Setting
   - ☐ Psych Mental Health Facility
   - ☐ Death Investigation Agency
   - ☐ Law Enforcement Agency
   - ☐ Criminal Justice Agency

4. Average number of Forensic patient encounters /visits per year at your primary place of employment:
   - ☐ <1,000
   - ☐ 1,000–5,000
   - ☐ 5,001–10,000
   - ☐ 10,001–20,000
   - ☐ 20,001–40,000
   - ☐ 40,001–60,000

5. Average number of Forensic patient encounters /visits per year for you individually:
   - ☐ <50
   - ☐ 150–100
   - ☐ 101–150
   - ☐ 151–200
   - ☐ 201–250
   - ☐ >250

To Do List

Date completed:

______________ Read this entire application, front to back.

______________ Determine whether you are/when you will be eligible.

______________ Download supplemental application materials and instructions at the ANCC website: **www.nursecredentialing.org**

______________ Follow instructions and complete the application package.

______________ For an in-depth review of practice, we also recommend *Forensic Nursing: Scope and Standards,* 2009 edition, co-published by the American Nurses Association and the International Association of Forensic Nurses. Available for purchase at **www.nursesbooks.org**

____

FILL OUT THE APPLICATION

Up to six months before your targeted portfolio review date, fill out the application, attaching all required documents.

Required attachments: (please mail everything together in one envelope)

Photocopy of nursing license
Photocopy of membership card (if you are claiming a discount)
All official transcripts with degree(s) conferred
Check (if paying by check)

____

MAIL APPLICATION

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.

____

RESULTS

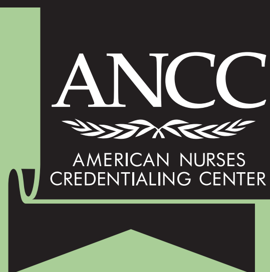
Portfolios are reviewed every six months.

If your portfolio is submitted by:	You will receive notice by:
March 1	June 1
September 1	December 1

______________ 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.

______________ After you receive portfolio recognition, please go to the ANCC website at **www.nursecredentialing.org** for instructions on renewal requirements and portfolio maintenance. The renewal cycle is every five years.

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.



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