AACN
CERTIFICATION
CORPORATION

Certification Organization for the American Association of Critical-Care Nurses

Exam Applications for Group Discount Program

Thank you for your interest in AACN Certification Corporation's exams and the group discount program!

The following information applies to individuals submitting their AACN certification exam application in the same package along with those of at least nine (9) other exam applicants.

If you are applying as part of a group of 10 or more to sit for the **CCRN, PCCN, CMC** or **CSC** exam *via computer-based testing*, please use the application on the following pages. Discounted group rates are as follows:

Exam	AACN Member	Nonmember
CCRN or PCCN	$225	$335
CMC or CSC	$120	$210

Applicants

- General policies for all AACN certification exam programs including day of exam rules, recognition and use of credentials, obtaining a duplicate score report and name or address changes are available in the *Certification Exam Policy Handbook* at www.aacn.org/certification > Preparation Tools & Handbooks.
- Eligibility and exam preparation information for the CCRN, PCCN, CMC and CSC exams is available in the corresponding exam handbook at www.aacn.org/certification > Preparation Tools & Handbooks.
- Review the handbook for your selected exam prior to applying for the exam and retain a copy for reference.
- Complete the 2-page application and 1-page honor statement in this handbook for your selected exam.
- Provide your completed exam application and fee to your group coordinator/contact person.

After Application is Submitted

- Once your application has been processed, you will receive an email from AACN with instructions about how to schedule your exam appointment. The email will also include the eligibility period during which you must schedule and take the exam.
- Upon receipt of your confirmation email from AACN, you will be able to promptly schedule your exam appointment by clicking the "Schedule Exam" button in your AACN customer dashboard, which will take you to the AACN Scheduling page.
    - Before choosing an exam date, you will be required to select one of two options by which to take your computer-based exam — at a PSI testing center or via live remote proctoring from your own computer/desk in a quiet, private location.
- A government-issued identification (ID) is required to gain admission to the exam. The ID must be current and include your **photograph and signature**. *No forms of military or temporary identification will be accepted*.
- For details regarding exam scheduling and taking your exam, refer to the *Certification Exam Policy Handbook*.

Exam Results

- Exam results will show on-screen, and a score report will be emailed to you within 24 hours after completion of computer-based exams.
- Successful candidates will be mailed their wall certificate approximately 3 to 4 weeks after testing.

Group Coordinators/Contact Persons

Please refer to page 12 for details about requesting the group discount and mailing of applications.

Thank you for your commitment to nursing certification.
For questions, please contact us at certification@aacn.org or call 800-899-2226, ext. 259.

Contents

Please direct inquiries to:

AACN Certification Corporation, 27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399
800-899-2226 • Fax: 949-362-2020 • certification@aacn.org

Please include your AACN customer number with all correspondence to AACN Certification Corporation.

Group Discount Exam Application

For use only by individuals submitting their exam application in the same envelope with at least 9 other applicants.

1. REGISTRATION INFORMATION

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.
LEGAL NAME AS IT APPEARS ON YOUR GOVERNMENT-ISSUED ID CARD IS REQUIRED FOR EXAM.

AACN CUSTOMER: _____ Number _____ Exp. Date **RN/APRN LICENSE:** _____ Number _____ State _____ Exp. Date

LEGAL NAME: _____ Last _____ First _____ MI _____ Maiden

HOME ADDRESS: _____ City _____ State _____ Zip

EMAIL: _____ **HOME PHONE:** _____

EMPLOYER NAME: _____ **BUSINESS PHONE:** _____

EMPLOYER ADDRESS: _____ City _____ State _____ Zip

2. AACN MEMBERSHIP

I would also like to join/renew/extend my AACN membership at this time and select member pricing for my exam fees:

(check one box only)

☐ 1-year AACN membership……..$78
☐ 2-year AACN membership……..$148
☐ 3-year AACN membership……..$200

AACN membership includes nonrefundable $12 and $15 one-year subscriptions to *Critical Care Nurse*® and the *American Journal of Critical Care*®, respectively. AACN dues are not deductible as charitable contributions for tax purposes, but may be deducted as a business expense in keeping with Internal Revenue Service regulations.

3. EXAM FOR WHICH YOU ARE APPLYING

Exam Type		Group Discount Exam Fee		Retest Fee	
		AACN Member	Nonmember	AACN Member	Nonmember
Check ***one*** *box only*	**CCRN or PCCN**	☐ $225	☐ $335	☐ $175	☐ $280
	CMC or CSC	☐ $120	☐ $210	☐ $115	☐ $160

☐ Check this box if you've attached a request and supporting documentation for special testing accommodations.

Membership Fee
$_____
+
Exam Fee:
$_____
=
Total Payment:
$_____

4. PAYMENT INFORMATION - *application must be accompanied by payment*

☐ Check or money order attached – *payable to AACN Certification Corporation. U.S. funds only.*

Bill my credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover Card

Credit Card # ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Exp. Date (mm/yy) ☐☐ / ☐☐

Name on Card _____ Signature _____

Amount Billed $_____ Address of Payor (if different than applicant) _____

☐ Please do not include my name on lists sold to other organizations.

Please complete pages 2 of application.

Group Discount Exam Application

NAME: _____ **AACN CUSTOMER #:** _____

Last First MI

5. DEMOGRAPHIC INFORMATION

Check **one** box in each category. Information used for statistical purposes and may be used in eligibility determination.

Primary Area Employed
- ☐ Acute Hemodialysis Unit (21)
- ☐ Burn Unit (13)
- ☐ Cardiac Rehabilitation (26)
- ☐ Cardiac Surgery/OR (36)
- ☐ Cardiovascular/Surgical ICU (09)
- ☐ Catheterization Lab (22)
- ☐ Combined Adult/Ped. ICU (23)
- ☐ Combined ICU/CCU (01)
- ☐ Coronary Care Unit (03)
- ☐ Corporate Industry (24)
- ☐ Crit. Care Transport/Flight (17)
- ☐ Direct Observation Unit (39)
- ☐ Emergency Dept. (12)
- ☐ General Med./Surg. Floor (18)
- ☐ Home Care (25)
- ☐ Intensive Care Unit (02)
- ☐ Interventional Cardiology (31)
- ☐ Long-Term Acute Care (27)
- ☐ Medical Cardiology (34)
- ☐ Medical ICU (04)
- ☐ Medical Surgical ICU (35)
- ☐ Neonatal ICU (06)
- ☐ Neuro./Neurosurgical ICU (10)
- ☐ Oncology Unit (19)
- ☐ Operating Room (15)
- ☐ Outpatient Clinic (29)
- ☐ Pediatric ICU (05)
- ☐ Private Practice (32)
- ☐ Progressive Care Unit (16)
- ☐ Recovery Room/PACU (14)
- ☐ Respiratory ICU (08)
- ☐ Stepdown Unit (30)
- ☐ Subacute Care (28)
- ☐ Surgical ICU (07)
- ☐ TeleICU (37)
- ☐ Telemetry (20)
- ☐ Trauma Unit (11)
- ☐ Other – specify below

_____ (99)

Primary Position Held
- ☐ Academic Faculty (07)
- ☐ Acute Care Nurse Practitioner (09)
- ☐ Bedside/Staff Nurse (01)
- ☐ Case Manager (39)
- ☐ Charge Nurse (45)
- ☐ Clinic Nurse (40)
- ☐ Clinical Coordinator (44)
- ☐ Clinical Director (04)
- ☐ Clinical Nurse Specialist (08)
- ☐ Corporate/Industry (11)
- ☐ Hospital Administrator (38)
- ☐ Internist (37)
- ☐ Legal Nurse Consultant (47)
- ☐ Manager (03)
- ☐ Nurse Anesthetist (02)
- ☐ Nurse Educator (46)
- ☐ Nurse Midwife (13)
- ☐ Nurse Practitioner (05)
- ☐ Outcomes Manager (42)
- ☐ Physician (16)
- ☐ Physician Assistant (17)
- ☐ Researcher (18)
- ☐ Respiratory Therapist (19)
- ☐ Technician (21)
- ☐ Unit Coordinator (22)
- ☐ Other - specify below

_____ (99)

Highest Nursing Degree
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Diploma
- ☐ Doctorate
- ☐ Master's Degree

Ethnicity
- ☐ African American (02)
- ☐ Asian (05)
- ☐ Hispanic (03)
- ☐ Native American (04)
- ☐ Pacific Islander (06)
- ☐ White/Non-Hispanic (01)
- ☐ Other – specify below

_____ (99)

Primary Type of Facility in Which Employed
- ☐ College/University (08)
- ☐ Community Hospital (Nonprofit) (01)
- ☐ Community Hospital (Profit) (02)
- ☐ Corporate/Industry (11)
- ☐ County Hospital (07)
- ☐ Federal Hospital (05)
- ☐ HMO/Managed Care (12)
- ☐ Home Health (13)
- ☐ Long-Term Acute Care Hosp. (16)
- ☐ Military/Government Hospital (04)
- ☐ Non-Academic Teaching Hosp. (14)
- ☐ Registry (10)
- ☐ Self-Employed (09)
- ☐ State Hospital (06)
- ☐ Travel Nurse (15)
- ☐ University Med. Ctr. (03)
- ☐ Other – specify below

_____ (99)

Number of Beds in Institution:

_____

Years of Experience in Nursing:

_____

Years of Experience in Acute/Critical Care Nursing:

_____

Date of Birth: (mm/dd/yy):

_____

Gender: ☐ Female ☐ Male

6. HONOR STATEMENT — 3rd page of application that must be submitted with this form.

Complete the Honor Statement for your selected exam. See pages 5 - 11.

7. SUBMIT APPLICATION

Attach Honor Statement to this application and submit with payment to your group coordinator/contact person.

NOTE: Allow **2 to 4 weeks** from the date received by AACN Certification Corporation for processing of exam applications submitted via the Group Discount Program.

Questions? Please visit www.aacn.org/certification, email certification@aacn.org or call us at 800-899-2226.

CCRN

CCRN Exam Honor Statement - Direct Care Pathway

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: _____ **AACN CUSTOMER #:** _____

Last First MI

I hereby apply for the CCRN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CCRN Exam Handbook - Direct Care Eligibility Pathway* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct care of acutely/critically ill patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application.

  OR

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in direct care of acutely/critically ill patients, with 144 of those hours accrued in the most recent year preceding application.

These clinical hours were in direct care of the following acutely/critically ill patient population:

☐ **Adult** ☐ **Pediatric** ☐ **Neonatal** *(check **one** box only)*

A majority of the total practice hours and those within the year prior to application for exam eligibility were focused on *critically* ill patients.

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name: _____ **Facility Name:** _____

Last First

Verifier's Phone Number: _____ **Verifier's Email Address:** _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ **Date:** _____

This application form may be photocopied and is also available online at www.aacn.org/certification.

CCRN

CCRN Exam Honor Statement - Knowledge Professional Pathway

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: _____ **AACN CUSTOMER #:** _____

Last First MI

I hereby apply for the CCRN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CCRN Exam Handbook - Knowledge Professional Eligibility Pathway* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

PRACTICE: I have fulfilled the practice requirement of 1,040 hours as an RN or APRN within the previous 2 years, with 260 of those hours accrued in the most recent year preceding application, during which I **applied knowledge in a way that influenced patients, nurses and/or organizations to have a positive impact on the care delivered to the following acutely/critically ill patient population**:

☐ **Adult** ☐ **Pediatric** ☐ **Neonatal** *(check **one** box only)*

A majority of the total practice hours and those within the year prior to application for exam eligibility were focused on *critically* ill patients.

I confirm that my practice is *not* exclusively or primarily in direct patient care. Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my supervisor or a professional colleague (RN or physician) who can verify that I have met the practice hour eligibility requirements:

Verifier's Name: _____ **Facility Name:** _____

Last First

Verifier's Phone Number: _____ **Verifier's Email Address:** _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ **Date:** _____

This application form may be photocopied and is also available online at www.aacn.org/certification.

CCRN

CCRN Exam Honor Statement - Tele-Critical Care Pathway

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: **AACN CUSTOMER #:**

Last First MI

I hereby apply for the CCRN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CCRN Exam Handbook - Tele-Critical Care Eligibility Pathway* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in the care of acutely/critically ill **adult** patients in a tele-critical care setting **(behind a camera)** *or* in a combination of tele-critical care and direct care during the past 2 years, with 875 of those hours accrued in the most recent year preceding application.

  OR

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in the care of acutely/critically ill **adult** patients in a tele-critical care setting **(behind a camera)** *or* in a combination of tele-critical care and direct care, with 144 of those hours accrued in the most recent year preceding application.

A majority of the total practice hours and those within the year prior to application for exam eligibility were focused on *critically* ill patients.

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name: **Facility Name:**

Last First

Verifier's Phone Number: **Verifier's Email Address:**

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: **Date:**

This application form may be photocopied and is also available online at www.aacn.org/certification.

PCCN

PCCN Exam Honor Statement - Direct Care Pathway

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: Last First MI **AACN CUSTOMER #:**

I hereby apply for the PCCN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *PCCN Exam Handbook - Direct Care Eligibility Pathway* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct care of acutely ill **adult** patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application.

  OR

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in direct care of acutely ill **adult** patients, with 144 of those hours accrued in the most recent year preceding application.

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of progressive care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name: Last First **Facility Name:**

Verifier's Phone Number: **Verifier's Email Address:**

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: **Date:**

PCCN

PCCN Exam Honor Statement - Knowledge Professional Pathway

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: Last First MI **AACN CUSTOMER #:**

I hereby apply for the PCCN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *PCCN Exam Handbook - Knowledge Professional Eligibility Pathway* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

PRACTICE: I have fulfilled the practice requirement of 1,040 hours as an RN or APRN within the previous 2 years, with 260 of those hours accrued in the most recent year preceding application, during which I **applied knowledge in a way that influenced patients, nurses and/or organizations to have a positive impact on the care delivered to acutely ill adult patients**.

I confirm that my practice is *not* exclusively or primarily in direct patient care. Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of progressive care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name: Last First **Facility Name:**

Verifier's Phone Number: **Verifier's Email Address:**

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: **Date:**

CMC

CMC Exam Honor Statement

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: _____ **AACN CUSTOMER #:** _____

Last First MI

I hereby apply for the CMC subspecialty certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CMC Exam Handbook* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

CLINICAL NURSING SPECIALTY CERTIFICATION: I hold a current clinical nursing specialty certification that meets AACN's criteria, which includes but is not limited to being nationally-accredited (ABSNC or NCCA). If my specialty certification is conferred by an organization other than AACN Certification Corporation, I agree to submit proof of my certification with this application. I understand that I must notify AACN if my specialty certification lapses.

To which clinical nursing specialty certification will your CMC credential be tied? _____

Attach proof of non-AACN certification, such as copy of wallet card or wall certificate, or verification letter from certifying organization; **must be valid for 90 days beyond CMC application date.**

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct care of acutely/critically ill **adult** patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application. Of those 1,750 hours, 875 were in the care of **adult cardiac** patients.

  OR

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in direct care of acutely/critically ill **adult** patients, with 144 of those hours accrued in the most recent year preceding application. Of those 2,000 hours, 1,000 were in the care of **adult cardiac** patients.

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name: _____ **Facility Name:** _____

Last First

Verifier's Phone Number: _____ **Verifier's Email Address:** _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ **Date:** _____

This application form may be photocopied and is also available online at www.aacn.org/certification.

CSC Exam Honor Statement

Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: _____ **AACN CUSTOMER #:** _____

Last First MI

I hereby apply for the CSC subspecialty certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CSC Exam Handbook* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current, unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation **within 30 days** if any provisions or conditions are placed against my RN or APRN license(s) in the future.

CLINICAL NURSING SPECIALTY CERTIFICATION: I hold a current clinical nursing specialty certification that meets AACN's criteria, which includes but is not limited to being nationally-accredited (ABSNC or NCCA). If my specialty certification is conferred by an organization other than AACN Certification Corporation, I agree to submit proof of my certification with this application. I understand that I must notify AACN if my specialty certification lapses.

To which clinical nursing specialty certification will your CSC credential be tied? _____

Attach proof of non-AACN certification, such as copy of wallet card or wall certificate, or verification letter from certifying organization; **must be valid for 90 days beyond CSC application date.**

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct care of acutely/critically ill **adult** patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application. Of those 1,750 hours, 875 were in the care of **adult cardiac surgery patients within the first 48 hours postoperatively.**

  OR

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in direct care of acutely/critically ill **adult** patients, with 144 of those hours accrued in the most recent year preceding application. Of those 2,000 hours, 1,000 were in the care of **adult cardiac surgery patients within the first 48 hours postoperatively.**

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet® designation or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name: _____ **Facility Name:** _____

Last First

Verifier's Phone Number: _____ **Verifier's Email Address:** _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification eligibility is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NONDISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ **Date:** _____

This application form may be photocopied and is also available online at www.aacn.org/certification.

Information for Group Coordinators/Contact Persons

AACN Certification Corporation offers discounted exam application fees to employers or AACN chapters submitting **ten (10) or more applications** together in one packet.

Different exams may be combined in the packet to reach the minimum number of 10 applications. Proper payment for each exam must accompany the applications.

The discounted group pricing varies for AACN members versus nonmembers. Nonmembers who wish to join at the same time they apply for the exam (as part of the group discount program) may pay $69 each for a year of AACN membership (regular annual AACN membership fee is $78) along with member pricing for their exam.

All applicants must meet eligibility requirements for their respective exam and thoroughly review the Certification Exam Policy Handbook and the exam handbook for their certification program *prior* to applying.

The group contact person is responsible for collecting and submitting all applications for the group and will need to:

- Set an internal due date to receive all applications.
- Collect all applications, honor statements and payments, and review for completeness.
- Use the cover sheet on the next page (or create your own form using a similar format) to list the names and exam types of all applicants in your group. The form must also note if membership is being purchased and an email address and phone number of the group contact person.
- Submit cover sheet, applications, honor statements and fee payment(s) in the same package to:

AACN Certification Corporation
Attn: Margie Elmi
27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399

The group contact person will be notified via email when the group of applications is received. An email and postcard with exam scheduling information will be sent to each applicant.

For questions, please email certification@aacn.org or call 800-899-2226, ext. 259.

Cover Sheet for Group Application Submissions

To be completed by group contact person and returned to AACN with 10 or more exam applications and fee payment(s).

GROUP CONTACT NAME: Last First MI **DATE:**

GROUP CONTACT EMAIL:

GROUP CONTACT PHONE NUMBER:

HOSPITAL OR CHAPTER NAME:

HOSPITAL OR CHAPTER CITY, STATE, ZIP:

Applicant Name	Exam Type	Membership Fees* Included	Exam Fees Included
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
Total # of applicants: *(10 or more needed)*		**Total for Membership Fees** $ ***For group members, $69 for 1 year**	**Total for Exam Fees** $
If more than 20 applicants, use additional sheet.		**Total Fee Payments(s) Included: $**	

NOTE: Group discount applicants are eligible for computer-based testing only.
Submit cover sheet, applications and fees to:

AACN Certification Corporation
Attn: Margie Elmi
27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399