2011 CRNI® Examination Application Form

MAIL TO INCC at
315 Norwood Park South
Norwood, MA 02062
(800) 434-INCC
Fax: (781) 440-9409
www.incc1.org

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

☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr.

Last Name ______________ First Name ______________ Middle Initial ________

INS Membership # ___ ___ ___ ___ ___ exp. date ______________ ☐ Joining INS ☐ Nonmember

PREFERRED ADDRESS

Title ______________ Company ______________ (if preferred address is business)

Address ______________ City ______________ State ________ Zip Code ________

(International Only) Province ______________ Country ______________ Postal Code ________

Preferred Address ☐ Home ☐ Business (affects mailings from INS and INCC)

Phone Number ______________

E-mail Address ______________

Which exam are you taking? ☐ March or ☐ September?

Application Deadlines		
Applications received after regular deadlines are not guaranteed acceptance and will incur a $50 late fee.	Early Bird Includes $50 discount	Regular
March Exam	**December 10, 2010**	**January 10, 2011**
September Exam	**June 10, 2011**	**July 10, 2011**
Initial Certification Exam Fees		
INS Member	☐ $285	☐ $335
Joining INS *(includes 1-year INS membership)*	☐ $375	☐ $425
Nonmember	☐ $410	☐ $460
Recertification by Examination *(includes $150 recertification fee)*		
INS Member	☐ $435	☐ $485
Joining INS *(includes 1-year INS membership)*	☐ $525	☐ $575
Nonmember	☐ $585	☐ $635

NOTE: INS Membership fees are nonrefundable.

Have you remembered to include the following?

- ☐ Documentation of your current, active, unrestricted RN license.
- ☐ Clinical Practice Documentation Form and Affirmation.
- ☐ Employer Appreciation Information.
- ☐ Any special requests with appropriate documentation.

Registration Fee (from selection in box) $ ________

☐ Check if you are retaking the exam $ ________
(Subtract $50 from appropriate registration fee if eligible – not valid for recertification)

☐ Check if a Group Discount Form is included $ ________
(Subtract $25 from appropriate registration fee if eligible)

☐ Other. Please specify
______________ $ ________

DISCOUNTS CANNOT BE COMBINED

TOTAL fee enclosed ☐

METHOD OF PAYMENT

☐ Check/money order (payable to INCC)

☐ MasterCard ☐ VISA ☐ AMEX

Card # ______________

Exp. Date ________

Signature ______________

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Employer Appreciation Information

Will your employer provide any financial support or reimbursement for maintaining or renewing your credential?

☐ Yes ☐ No

If applicable, do you authorize INCC to contact your employer to thank them for their support?

☐ Yes ☐ No

If applicable, please provide name and address of the administrator.

Name____

Title____

Company Name ________________________________

Address _____________________________________

____

INCC does not discriminate among candidates on the basis of age, gender, race, religion, national origin, disability, sexual orientation, or marital status.

Clinical Practice Documentation and Affirmation Form

This form is for new certification candidates only.
Recertification candidates should use the form found in the CRNI® *Recertification Handbook*.

Affirmation

By signing and submitting this Affirmation Form, I accept the conditions stated in the Infusion Nurses Certification Corporation CRNI® *Bulletin* concerning the administration of the exam, the reporting of scores, the release of information to INS, and the certification and recertification processes and policies. I certify that the information in this application is true, complete, and correct to the best of my knowledge and is made in good faith. I understand that if any information is later determined to be false, INCC reserves the right to revoke any certification granted on the basis of that false information. I understand that if I take the 2011 CRNI® Examination as a means to recertify, I forfeit the option to recertify through continuing education. I understand that the proctors at any assigned test center are authorized by me to take all actions they deem necessary and proper to administer the test securely, fairly, and efficiently. I acknowledge that the proctors may relocate me before or during the exam.

I further affirm that no nursing licensing authority has taken any disciplinary action in relation to my license to practice nursing in any state, and that my license to practice nursing has not been suspended or revoked by any state or jurisdiction.

_______________________________________ ________________

Candidate Signature Date

Clinical Practice Documentation

Certification candidates must submit written verification that they meet the clinical practice eligibility criteria for taking the exam. They should be involved in assessing, planning, implementing, and evaluating the care and needs of patients and clients who require infusion therapy in the course of their care. 1,600 hours of direct clinical bedside experience is not a prerequisite; registered nurses functioning as educators, administrators, or researchers in the infusion nursing practice are also eligible. The minimum requirement for clinical practice is 1,600 hours within the two years prior to the date of application.

Please ask your supervisor to sign this Documentation Form. You may duplicate the form and have it completed by as many former employers as it takes to provide evidence of infusion experience equivalent to 1,600 hours within the two years prior to the date of application.

Candidate's name (please print or type)_______________________________________

The individual named above is applying for CRNI® certification. Eligibility criteria require candidates to document their clinical experience during the previous two years.

Please complete the following to document the candidate's clinical experience, as defined above.

I verify that ________________________________ was actively involved in the infusion nursing specialty for a minimum of 1,600 total hours within the previous two years.

_______________________________________ ________________

Supervisor's Signature Date

_______________________________________ ________________

Supervisor's Name Title

____

Company

____

Address

_______________________________________ ________________

City State

_______________________________________ ________________

Zip Code Telephone

Group Discount Application Form (if applicable)

A discount of $25 per person is available to groups of five or more applicants. All applications must be submitted in **ONE** envelope, along with a copy of this form, to qualify for the group discount. Transferring candidates are **NOT** eligible.

1) Name of Organization ______________________________

Contact Name ______________ Telephone ______________ E-mail ______________

2) Indicate on the lines below each candidate's name.

Special Accommodation Request Form (if applicable)

Special Accommodations for Candidates with Disabilities

In compliance with the Americans with Disabilities Act of 1990, all reasonable special requests will be accommodated. Complete this Special Accommodation Request Form and submit it to INCC, with your application and fee, and a letter stating your requirements from a healthcare or education professional. *Applications for special accommodations must be received by regular deadlines*.

Scheduling Your Exam

Candidates requesting a special accommodation must schedule their exam by calling AMP at (888) 519-9901.

Candidate Name ______________ (Last) ______________ (First) ______ (MI)

Test Site Location ______________________________

Please describe briefly the special accommodations you will need ______________________________

______________________________ (Signature)