

2018 CSSM™ Recertification Application

APPLICATION CHECKLIST

The following must be included with your application. All fields and questions are required; incomplete submissions will be returned.

- CSSM recertification application
- RN License (copies acceptable)
- Currently employed in perioperative nursing surgical services management role and worked a minimum of 1500 hours within the 3 years recertification cycle.
- CSSM professional points activity logged into the CCI database or verified by CCI staff.
- Payment

APPLICATION SUBMISSION

The application deadline is **November 30, 2018**. All applications must be postmarked by this date. Candidates must complete self assessment by **December 15, 2018**. Mail, Email, or Fax your application, supporting documents and payment to:

CCI
Attn: CSSM Exam
2170 S. Parker Road, Suite 120
Denver, CO 80231
Email: info@cc-institute.org • Fax: 303-695-8464

Questions? Visit cc-institute.org or contact us at info@cc-institute.org or 888-257-2667.

APPLICANT INFORMATION

Legal Name (as shown on driver's license or passport) Last 4 digits of SSN Birth Year

Address City State Zip

Home Work Cell

Primary Phone Primary E-mail (all communications will be sent to this email address)

CSSM RECERTIFICATION FEE

Non-CNOR Certified - \$250

CNOR-Certified - \$195

If CNOR, provide CCI ID number _____

PAYMENT INFORMATION

Check or Money Order (Make payable to "CCI") Visa Mastercard Discover Card American Express

Credit Card Number (required for credit card payment) Expiration Month/Year Security Code

Card Holder Signature Billing Zip Code Today's Date

EXPERIENCE

Applicants must be currently employed and completed a minimum of 1500 hours in a surgical services management role within the 3 year recertification cycle.

Current Employer		Title	
Employer Address			
City		State	Zip
Work Phone		Work E-mail	
Start Date	Hours per Week		
Supervisor	Supervisor's Phone	Supervisor's Email	

Past Employer		Title	
Start Date	End Date	Hours per Week	
Employer Address			
City		State	Zip
Work Phone		Work E-mail	
Supervisor	Supervisor's Phone	Supervisor's Email	

LICENSURE

State in which you are currently licensed: _____ Exp. Date: _____

CURRENT POSITION

- | | | |
|---|--|--|
| <input type="checkbox"/> Administrator/VP | <input type="checkbox"/> Staff Nurse | <input type="checkbox"/> Health Care Industry Representative |
| <input type="checkbox"/> Director/Manager | <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Consultant |
| <input type="checkbox"/> Researcher | <input type="checkbox"/> Faculty | |
| <input type="checkbox"/> Charge Nurse | <input type="checkbox"/> Traveling Nurse | |
| <input type="checkbox"/> Educator | <input type="checkbox"/> Supervisor/Coordinator | |

TYPE OF FACILITY

- | | | |
|--|---|---|
| <input type="checkbox"/> Academic Institution | <input type="checkbox"/> Ambulatory – Office-based | <input type="checkbox"/> Physician/Surgeon Office |
| <input type="checkbox"/> Agency/Travel Nurse | <input type="checkbox"/> Clinic | <input type="checkbox"/> Self-Employed |
| <input type="checkbox"/> Ambulatory – Free standing | <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Ambulatory – Hospital-based | <input type="checkbox"/> Military/Government Facility | |

ATTESTATION STATEMENTS

Failure to complete all steps will result in your certification lapsing.

REQUIRED

- I attest that I have logged my professional points activity into the CCI database or that my points activities have been reviewed by CCI staff.
- I understand that I must complete the CSSM recertification application and fee by **November 30, 2018**.
- I understand that I must schedule and take the self assessment at a Prometic testing center by **December 15, 2018**.

**Successful completion of the self assessment will determine criteria for your next recertification cycle.*

STATEMENT OF UNDERSTANDING

I hereby apply for recertification offered by the Competency & Credentialing Institute (CCI). I understand that the recertification depends upon the successful completion of the specified requirements. I further understand that the information acquired in the recertification process may be used for statistical purposes and for evaluation of the certification program. I further understand that the information from my recertification records shall be held in confidence and shall not be used for any other purposes without my permission. To the best of my knowledge, the information contained in this application is true, complete, correct and made in good faith. I understand that information supplied is subject to audit, and that failure to respond to a request for further information will result in termination of the application process. I understand that CCI reserves the right to verify all information on this application..

I affirm and attest that I have read and agree to abide by the Statement of Understanding.

Signature: _____

Print Name: _____ Date _____

ADA ACCOMMODATION

Whenever possible, CCI is committed to providing reasonable accommodation in its examination processes to otherwise qualified individuals with physical or mental disabilities in accordance with the Americans with Disabilities Act (ADA). Accommodations will be provided to qualified candidates with disabilities to the extent that such accommodation does not fundamentally alter the examination or cause an undue burden to the agency.

CHOOSE ONE OF THE FOLLOWING

- I do NOT require ADA accommodations,
- I DO require ADA accommodations.

Please indicate the type of accommodation below. Should you require a different type of accommodation, please contact CCI prior to the sending of your application.

- Separate room
- Time and a half