2019 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, 2019.** All applications must be postmarked by this date. Candidates must complete self assessment by **December 31, 2019**. 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 Last Name (as shown on driver's license or passport) _____ Legal First Name _____ Birth Year _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ ❒ Home ❒ Work ❒ Cell

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 _____

CCI
www.cc-institute.org
888-257-2667

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

- ❒ Administrator/VP
- ❒ Director/Manager
- ❒ Researcher
- ❒ Charge Nurse
- ❒ Educator
- ❒ Staff Nurse
- ❒ Clinical Nurse Specialist
- ❒ Faculty
- ❒ Traveling Nurse
- ❒ Supervisor/Coordinator
- ❒ Health Care Industry Representative
- ❒ Consultant

TYPE OF FACILITY

- ❒ Academic Institution
- ❒ Agency/Travel Nurse
- ❒ Ambulatory – Free standing
- ❒ Ambulatory – Hospital-based
- ❒ Ambulatory – Office-based
- ❒ Clinic
- ❒ Hospital
- ❒ Military/Government Facility
- ❒ Physician/Surgeon Office
- ❒ Self-Employed

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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, 2019.**
- ❒ I understand that I must schedule and take the self assessment at a Prometic testing center by **December 31, 2019.**

**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

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