2018 CNS-CP™ Certification Application

APPLICATION CHECKLIST

The following must be included with your application. Incomplete submissions will be returned.

- ❒ CNS-CP certification application
- ❒ Original transcript demonstrating completion of CNS program (copies not acceptable)
- ❒ Current resume / CV
- ❒ Verification of current RN and/or APRN licensure from your State Board of Nursing (copies acceptable)
- ❒ If held, verification of CNS certification (copy of certificate or wallet card is acceptable)
- ❒ Payment

APPLICATION SUBMISSION

Questions? Visit cc-institute.org or contact us at info@cc-institute.org or 888-257-2667.
Mail your application, supporting documents and payment to:

CCI / CNS-CP Exam
2170 S. Parker Road, Suite 120
Denver, CO 80231

CNS-CP CERTIFICATION FEE

The testing fee is $425. Payment must accompany application.

APPLICANT INFORMATION (All fields required)

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

Address _____ City _____ State _____ Zip _____

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

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

To be eligible, you must have two years and 2,400 hours of perioperative experience as an RN. Starting with your current employer, list only the employers with whom you attained 2 years and 2,400 hours' experience. Attach additional pages if necessary.

Current Employer _____ Title _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____ Work E-mail _____

Start Date ___/___/___ Hours perWeek _____

Supervisor _____ Supervisor's Phone _____ Supervisor's Email _____

Past Employer _____ Title _____

Start Date ___/___/___ End Date ___/___/___ Hours perWeek _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____ Work E-mail _____

Supervisor _____ Supervisor's Phone _____ Supervisor's Email _____

LICENSURE

Issue Date of first RN License: ___/___/___ Start date in OR as an RN: ___/___/___

State in which you are currently licensed: _____

EDUCATION

❒ MS in Nursing ❒ Doctorate in Nursing (PhD or DNP) ❒ Other

Year accredited CNS program completed: _____ Start date as Perioperative CNS: ___/___/___

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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MAGNET® STATUS OF CURRENT FACILITY

❒ Have Magnet designation ❒ Do not have Magnet designation ❒ Working towards Magnet designation

ADVANCED PRACTICE POPULATION FOCUS

❒ Family/Individual across lifespan ❒ Women's Health/Gender Related ❒ Pediatrics
❒ Adult-Gerontology ❒ Neonatal ❒ Psych/Mental Health

CERTIFICATION REQUIREMENTS

Check the appropriate boxes to demonstrate your eligibility.

REQUIRED

❒ I am employed as a perioperative RN, **AND**
❒ I have completed a minimum of two years and 2,400 hours of experience in perioperative nursing, with a minimum of 50% (1,200 hours) in the intraoperativesetting.

Candidates must meet at least one requirement in each of the three categories below.

1. LICENSURE

❒ I am currently licensed, without provision or condition, as an RN and/or APRN in the US, **OR**
❒ I am currently licensed, without provision or condition, as an RN and am recognized as a CNS by my State Board of Nursing.

2. EDUCATION

❒ I have completed a CNS track in a master's or doctoral program in nursing. The program contained both didactic (advanced pharmacology, pathophysiology, and physical assessment) and clinical components, **OR**
❒ In lieu of the 3 Ps and 500 hour practicum, I have completed at minimum a master's degree in nursing along with documentation of serving in an advanced practicerole.

3. EXPERIENCE

❒ I have graduated from a CNS program with current accreditation standards (advanced pharmacology, physical assessment and pathophysiology and 500 clinical hours), **OR**
❒ My program did not meet current accreditation standards. I have worked 2,400 hours and two years as a practicing CNS.

STATEMENT OF UNDERSTANDING

I hereby apply for certification offered by the Competency & Credentialing Institute (CCI). I understand that certification depends upon the successful completion of the specified requirements. I further understand that the information acquired in the certification process may be used for statistical purposes and for evaluation of the certification program. I further understand that the information from my certification 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.

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. Candidates with disabilities must notify CCI in writing no later than 60 days prior to the examination testing window stating the specific type of accommodation needed and providing appropriate documentation of the disability. Please refer to the CNS-CP Candidate Handbook for more information.

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

Signature: _____

Print Name:_____Date_____/_____/_____

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