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:

2. AACN MEMBERSHIP

I would also like to join/renew my AACN membership at this time and *select member pricing* for my exam fees: *(check only one box)*

- ☐ 1-year AACN membership.....$69 (special group program rate, regular rate $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 Fees		Retest Fees	
		AACN Member	Nonmember	AACN Member	Nonmember
Check ***one*** *box only*	**CCRN, CCRN-K or CCRN-E**	☐ $205	☐ $310	☐ $170	☐ $275
	PCCN or PCCN-K	☐ $155	☐ $255	☐ $135	☐ $215
	CMC or CSC	☐ $100	☐ $185	☐ $110	☐ $155

☐ 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 page 2 of application.

GROUP DISCOUNT EXAM APPLICATION

PRINTED NAME **AACN#**

6. 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)
☐ Tele-ICU (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

7. HONOR STATEMENT - 3rd page of application that must be submitted with this form

Complete the Honor Statement for your selected exam:
CCRN - page 5, CCRN-K - page 6, CCRN-E - page 7, PCCN - page 8, PCCN-K - page 9, CMC - page 10, CSC - page 11

8. 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 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.

Did you include your signed honor statement and fee payment?

CCRN 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 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* 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 any state board of nursing and has no provisions or conditions that limit my practice in any way. This applies to all RN or APRN licenses I currently hold. I understand that I must notify AACN Certification Corporation **within 30 days** if any disciplinary action is taken 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 for at least 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 application 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.

NON-DISCLOSURE 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 form may be photocopied and is also available at www.aacn.org/certification.

PCCN

PCCN 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 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* 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 any state board of nursing and has no provisions or conditions that limit my practice in any way. This applies to all RN or APRN licenses I currently hold. I understand that I must notify AACN Certification Corporation **within 30 days** if any disciplinary action is taken 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 for at least 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 of 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:** _____

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