EXAM APPLICATIONS FOR GROUP DISCOUNT PROGRAM

The following information applies to individuals submitting their AACN certification exam application in the same package along with those of at least nine (9) other exam applicants.

Thank you for your interest in AACN Certification Corporation’s exams and the group discount program!

If you are applying as part of a group of 10 or more to sit for the CCRN, CCRN-K, CCRN-E, PCCN, PCCN-K, CMC or CSC exam via computer-based testing, please use the application on the following pages. Discounted group rates are as follows:

<table>
<thead>
<tr>
<th>Exam</th>
<th>AACN Members</th>
<th>Nonmembers</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCRN, CCRN-E or CCRN-K</td>
<td>$205</td>
<td>$310</td>
</tr>
<tr>
<td>PCCN or PCCN-K</td>
<td>$155</td>
<td>$255</td>
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<tr>
<td>CMC or CSC</td>
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<td>$185</td>
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ELIGIBILITY AND EXAM PREPARATION INFORMATION

Eligibility and exam preparation information for the CCRN, CCRN-K, CCRN-E, PCCN, PCCN-K, CMC and CSC exams is available in the corresponding exam handbook at www.aacn.org/certification > Preparation Tools & Handbooks.

APPLICANTS

• General policies for all AACN certification exam programs including day of exam rules, recognition and use of credentials, obtaining a duplicate score report and name or address changes are available in the Certification Exam Policy Handbook at www.aacn.org/certification > Preparation Tools & Handbooks.
• Eligibility and exam preparation information for the CCRN, CCRN-K, CCRN-E, PCCN, PCCN-K, CMC and CSC exams is available in the corresponding exam handbook at www.aacn.org/certification > Preparation Tools & Handbooks.
• Review the handbook for your selected exam prior to applying for the exam and retain a copy for reference.
• Complete the 2-page application and 1-page honor statement in this handbook for your selected exam.
• Provide your completed exam application and fee to your group coordinator/contact person.

AFTER APPLICATION IS SUBMITTED

• Once your application has been processed, you will receive an email and postcard from our testing service, Applied Measurement Professionals, Inc. a PSI business (PSI/AMP), confirming your registration.
• Your email and postcard will include exam scheduling information and the 90-day window during which you must schedule and sit for your computer-based exam.
• Upon receipt of your postcard or email, promptly call or go online to schedule your testing appointment.
• For admission to the testing center, you must provide your testing ID number and present 2 pieces of identification, 1 with a current photograph. No forms of temporary identification will be accepted.
• Testing is offered 6 days per week, twice daily at more than 300 PSI/AMP testing centers across the U.S. Locate your nearest computer-based testing center at www.goAMP.com.

EXAM RESULTS

• Results of your exam will be provided on-site upon completion of the computer-based exam.
• Those who pass the exam will also receive a wall certificate by mail within 3 to 4 weeks of testing.

GROUP COORDINATORS/CONTACT PERSONS

Please refer to page 12 for details about requesting the group discount and mailing of applications.

Thank you for your commitment to nursing certification.
For questions, please contact us at certification@aacn.org or call 800-899-2226, ext. 265.
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: RN/APRN LICENSE:

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<tr>
<th>Number</th>
<th>Exp. Date</th>
<th>Number</th>
<th>State</th>
<th>Exp. Date</th>
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LEGAL NAME:

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<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Maiden</th>
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HOME ADDRESS:

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<th>City</th>
<th>State</th>
<th>ZIP</th>
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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

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<th>Exam Type</th>
<th>Group Discount Exam Fees</th>
<th>Retest Fees</th>
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<td>AACN Member</td>
<td>Nonmember</td>
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<td>Check one box only</td>
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<tr>
<td>CCRN, CCRN-K or CCRN-E</td>
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<td>CMC or CSC</td>
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☐ Check this box if you've attached a request and supporting documentation for special testing accommodations.

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) Exp. Date

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.

This application form may be photocopied and is also available online at www.aacn.org/certification.
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)
☐ Steptown Unit (30)
☐ Subacute Care (28)
☐ Surgical ICU (07)
☐ Tele-ICU (37)
☐ Telemetry (20)
☐ Trauma Unit (11)
☐ Other – specify below

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

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

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

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.
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:**

**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 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  

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.
AACN Certification Corporation offers discounted exam application fees to employers or AACN chapters submitting **ten (10) or more applications together** in one packet.

Different exams may be combined in the packet to reach the minimum number of 10 applications. Proper payment for each exam must accompany the applications.

The discounted group pricing varies for AACN members versus nonmembers. Nonmembers who wish to join at the same time they apply for the exam (as part of the group discount program) may pay $69 each for a year of AACN membership (regular annual AACN membership fee is $78) along with member pricing for their exam.

All applicants must meet eligibility requirements for their respective exam and thoroughly review the *Certification Exam Policy Handbook* and the exam handbook for their certification program **prior** to applying.

The group contact person is responsible for collecting and submitting all applications for the group and will need to:

- Set an internal due date to receive all applications.
- Collect all applications, honor statements and payments, and review for completeness.
- Use the cover sheet on the next page (or create your own form using a similar format) to list the names and exam types of all applicants in your group. The form must also note if membership is being purchased and an email address and phone number of the group contact person.
- Submit cover sheet, applications, honor statements and fee payment(s) in the same package to:

  **Jean Evingham, Customer Care**  
  **AACN Certification Corporation**  
  **101 Columbia, Aliso Viejo, CA 92656**

The group contact person will be notified via email when the group of applications is received. An email and postcard with exam scheduling information will be sent to each applicant.

For questions, please email certification@aacn.org or call 800-899-2226, ext. 265.
# COVER SHEET FOR GROUP APPLICATION SUBMISSIONS

*To be completed by group contact person and returned to AACN with 10 or more exam applications and fee payment(s).*

**GROUP CONTACT NAME:** Last Name    First Name

**GROUP CONTACT EMAIL ADDRESS:**

**GROUP CONTACT PHONE NUMBER:**

**HOSPITAL OR CHAPTER NAME:**

**HOSPITAL OR CHAPTER CITY, STATE, ZIP:**

<table>
<thead>
<tr>
<th>Applicant Name</th>
<th>Exam Type</th>
<th>Membership Fees* Included</th>
<th>Exam Fees Included</th>
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**Total # of applicants:**
(10 or more needed)

*If more than 20 applicants, use additional sheet.*

**Total Fee Payment(s) Included:**

**Total for Membership Fees**

$ *

*For group members, $69 for 1 year

**Total for Exam Fees**

$ *

NOTE: Group discount applicants are eligible for computer-based testing only.

Submit cover sheet, applications and fees to:

Jean Evingham, Customer Care
AACN Certification Corporation
101 Columbia, Aliso Viejo, CA 92656