



CERTIFIED REGISTERED NURSE INFUSION-RETIRED (CRNI-R)

APPLICATION FORM

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

CRNI[®] expiration date: _____

PREFERRED MAILING ADDRESS

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

I hereby attest that I have read and understand the INCC policy on CRNI-R status. I accept that the terms and conditions of CRNI-R status shall be binding. I retire/d from active clinical nursing practice on _____ (date) and have no immediate intention of returning to active clinical practice. I attest that I shall not use the CRNI-R status in active practice as an RN. If I choose to regain my CRNI[®] status I agree to meet the requirements currently applicable for initial certification. I hereby apply for Certified Registered Nurse Infusion – Retired (CRNI-R) status and verify that all information provided here is correct to the best of my knowledge.

Signature of Candidate _____ Date _____

I enclose the CRNI-R registration fee of \$75 payable by

Check/Money Order

MasterCard/VISA/AMEX # _____

Expiration date _____

Signature _____

Include letter of retirement from your employer

Once your application, letter of retirement, and \$75 fee has been received and approved by INCC, your CRNI-R certificate will be mailed to you. Please allow 4-6 weeks for delivery.

Mail to INCC, 315 Norwood Park South, Norwood, MA 02062 or Fax to (781) 440-9409

Please call 800-434-INCC or e-mail Julie.smiley@ins1.org with questions or concerns.