



2010 CRNI® Recertification Application Form

Use this application for Recertification
by Continuing Education

MAIL TO INCC at
315 Norwood Park South
Norwood, MA 02062
(800) 434-INCC
Fax: (781) 440-9409
www.incc1.org

Ms. Mrs. Mr. Dr.

Last Name _____ First Name _____ Middle Initial _____
(as it will appear on your certificate)

Credentials _____

INS Membership # _____ exp. date _____ Joining INS Nonmember

Phone Number _____ Home Business Cell

E-mail Address _____

ADDRESS Home Business (affects mailings from INS and INCC)

Business Name _____ Title _____ (if applicable)

Street Address _____

City _____ State _____ Zip Code _____

Province (International Only) _____ Country _____ Postal Code _____

Recertification by Continuing Education* Application Fees and Deadlines		
Received by	Regular December 31	Late January 31
INS Member	<input type="checkbox"/> \$150	<input type="checkbox"/> \$200
Rejoin/First-time Member Joining INS <small>(includes 1-year INS membership)</small>	<input type="checkbox"/> \$240	<input type="checkbox"/> \$290
Nonmember	<input type="checkbox"/> \$250	<input type="checkbox"/> \$300

Application Fee (from selection in box) \$

METHOD OF PAYMENT

Check/money order (payable to INCC)

MasterCard VISA AMEX

Card # _____

Exp. Date _____

Signature _____

Have you remembered to include the following?

Documentation of your current, active, unrestricted RN license

Clinical Practice Documentation Form and Affirmation

Biographical Questionnaire

Documentation of recertification units (if applicable)

*To recertify by exam, please use the Recertification by Examination Application Form on page 9. Examination Policies and Procedures are included in the CRNI® *Bulletin*. Visit www.incc1.org for your copy.

Recertification Clinical Practice Documentation and Affirmation Form

This form is for recertification candidates only.

First-time certification candidates use the form in the CRNI® Bulletin. Call (800) 434-INCC to request a copy.

Recertification candidates must submit written verification that they meet the clinical practice eligibility criteria for recertification. They should be involved in assessing, planning, implementing, and evaluating the care and needs of patients and clients who require infusion therapy in the course of their care—1,000 hours of direct clinical bedside experience is not a prerequisite. Registered nurses functioning as educators, administrators, or researchers in the infusion nursing practice are also eligible. The minimum requirement for clinical practice is 1,000 hours within the three-year certification period ending December 31, 2010.

Please ask your supervisor to sign this Documentation Form. You may duplicate the form and have it completed by as many former employers as it takes to provide evidence of infusion nursing specialty practice experience equivalent to 1,000 hours within the previous three years.

Candidate's name (please print or type) _____

The individual named above is applying for CRNI® recertification. Eligibility criteria require candidates to document their clinical experience during the previous three years.

Please complete the following to document the candidate's clinical experience, as defined above:

I verify that _____ was actively involved in the infusion nursing specialty for a minimum of 1,000 total hours within the previous three years.

_____ Supervisor's Signature	_____ Date
_____ Supervisor's Name	_____ Title
_____ Facility	
_____ Address	
_____ City	_____ State
_____ Zip Code	_____ Telephone

Affirmation: By signing and submitting this Recertification Application, I accept the conditions stated in the Infusion Nurses Certification Corporation's CRNI® *Recertification Handbook* concerning the certification and/or recertification processes and policies. I certify that the information in this application is true, complete, and correct to the best of my knowledge and is made in good faith. I understand that if any information is later determined to be false, INCC reserves the right to revoke any certification granted on the basis of that false information.

I further affirm that no nursing licensing authority has taken any disciplinary action in relation to my license to practice nursing in any state, and that my license to practice nursing has not been suspended or revoked by any state or jurisdiction.

Candidate Signature

Date

Biographical Questionnaire

Name: _____

Please answer every question. For each item, select the ONE response that best describes your current status.

1. Date of Birth

2. Years actively practicing as an RN

3. Years practicing infusion nursing

4. Current practice setting (Check only the ONE that best describes your current practice setting.)

- Hospital
- Hospice
- Ambulatory Clinic
- Industry
- Pharmacy
- Long-Term Care
- Education
- Homecare
- Other (specify) _____

5. Current professional position (Check only the ONE that best describes your current professional position.)

- Staff Nurse
- Infusion Staff Nurse
- Education
- Administration
- Manager
- Consultant
- Pharmacy-related
- Industry
- Other (specify) _____

6. Education (Please check ONLY the highest level of degree received.)

- Diploma Nursing
- Associate Degree Nursing
- Baccalaureate
- Master's
- Doctorate

7. Which best describes your nursing specialty?

- Pediatrics
- Oncology
- Parenteral Nutrition
- Transfusion Therapy
- Pharmacology
- Infusion Therapy
- Geriatrics
- Research
- Education
- Administration
- Emergency Nursing
- Critical Care
- Dermatology
- Rheumatology
- Medical/Surgical
- Other

8. Will your employer provide any financial support or reimbursement for maintaining or renewing your credential?

Yes No

If applicable, do you authorize INCC to contact your employer to thank them for their support?

Yes No

If applicable, please provide name and address of the administrator

Name _____

Title _____

Company Name _____

Address _____

INCC does not discriminate among candidates on the basis of age, gender, race, religion, national origin, disability, sexual orientation, or marital status.



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Business Name _____ Title _____ (if applicable)

Address _____

City _____ State _____ Zip Code _____

Province (International Only) _____ Country _____ Postal Code _____

Recertification by Exam Application Deadlines		
	Early Bird includes \$50 discount	Regular
September Exam	June 10, 2010	July 10, 2010
Recertification by Exam Fees <i>(includes \$150 recertification fee)</i>		
INS Member	<input type="checkbox"/> \$435	<input type="checkbox"/> \$485
Joining INS <i>(includes 1-year INS membership)</i>	<input type="checkbox"/> \$525	<input type="checkbox"/> \$575
Nonmember	<input type="checkbox"/> \$585	<input type="checkbox"/> \$635

NOTE: INS Membership fees are nonrefundable.

Have you remembered to include the following?

- Documentation of your current, active, unrestricted RN license
- Clinical Practice Documentation Form and Affirmation
- Biographical Questionnaire
- Any special requests with appropriate documentation (see p. 10)

Registration Fee (from selection in box) \$ _____

Check if a Group Discount Form is included (see p. 10) \$ _____

Other, please specify _____ \$ _____

DISCOUNTS CANNOT BE COMBINED

TOTAL fee enclosed

METHOD OF PAYMENT

Check/money order (payable to INCC)

MasterCard VISA AMEX

Card # _____

Exp. Date _____

Signature _____

Please consult the CRNI® *Bulletin* for complete exam policies and procedures. Visit www.incc1.org for your copy.

Group Discount Application Form (if applicable)

A discount of \$25 per person is available to groups of five or more new applicants. All applications must be submitted in **ONE** envelope, along with a copy of this form, to qualify for the group discount. Transferring candidates are **NOT** eligible.

1) Name of Organization _____

2) Indicate on the lines below each candidate's name.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Contact Name	Telephone	E-mail

Special Accommodation Request Form (if applicable)

Special Accommodations for Candidates with Disabilities

In compliance with the Americans with Disabilities Act of 1990, all reasonable special requests will be accommodated. Complete this Special Accommodation Request Form and submit it to INCC, with your application and fee, and a letter stating your requirements from a healthcare or education professional. *Applications for special accommodations must be postmarked by regular deadlines.*

Scheduling Your Exam

Candidates requesting a special accommodation must schedule their exam by calling AMP at (888) 519-9901.

Candidate Name _____
(Last) (First) (MI)

Test Site Location _____

Please describe briefly the special accommodations you will need _____

(Signature)



Study Aid Order Form

MAIL TO INCC at
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Study Aids can also be ordered at www.incc1.org.

	Quantity	Price		Total
CRNI® Exam Preparation Guide and Practice Questions		\$20		
CRNI® Exam Preparatory Review CD-ROM		\$60		
		Member	Nonmember	
Core Curriculum for Infusion Nursing, 3rd ed. (2003)		\$51	\$55	
Infusion Nursing: An Evidence-Based Approach, 3rd ed. (2010)		\$97	\$107	
Policies and Procedures for Infusion Nursing, 3rd ed. (2006)		\$52	\$65	
Infusion Nursing Standards of Practice (2006)		\$18	\$51	
Massachusetts Residents add 6.25% Tax				
Shipping and Handling (see below)				
Total				

NOTE: If you are joining INS with your exam application, you qualify for member rates. Your exam application must accompany this order form.

Check here if joining INS with enclosed exam application forms.

INS Membership Number _____ Exp. Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Province _____ Country _____

Phone _____ Fax _____

E-mail _____

METHOD OF PAYMENT

Check made payable to INCC

Credit Card MasterCard VISA AMEX

Credit Card Number _____ Exp. Date _____

Signature _____

Shipping & Handling
Orders up to:

\$75.	\$10.00
\$120.	\$12.00
\$150.	\$15.00
over \$225.	\$18.00

Please note: All orders are shipped ground. For shipping outside the US, or to Alaska and Hawaii, an additional shipping charge may apply.