



# 2011 CRNI® Recertification Application Form

Use this application for Recertification  
by Continuing Education

Apply online or mail to:  
**INCC**  
315 Norwood Park South  
Norwood, MA 02062  
**Fax to:** (781) 440-9409

Use your legal name on the application. This name will be the name printed on your certificate.

Last Name	First Name	Middle Initial
INS Membership #	Exp. Date	<input type="checkbox"/> Re/Joining INS <input type="checkbox"/> Nonmember

**PREFERRED ADDRESS**    Home    Business

Title		Company (if preferred address is business)	
Address	City	State	Zip Code
(International Only) Province		Country	Postal Code
Phone Number		E-mail Address	
RN license #	State	Exp. Date	

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 \_\_\_\_\_

\*To recertify by exam, please use the Recertification by Examination Application Forms. Examination Policies and Procedures are included in the CRNI® Exam Handbook. Visit [incc1.org](http://incc1.org) for your copy.

# Recertification Clinical Practice Documentation and Affirmation Form

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Last Name

First Name

Middle Initial

## *Affirmation*

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 my nursing license is current, active, and unrestricted.

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Candidate Signature

Date

## Clinical Practice Statement

### *Recertification candidates only*

My signature below serves to document that as a recertification candidate, I have at least 1,000 hours of clinical experience\* in infusion therapy, earned as an RN within the three-year recertification period.

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Recertification candidate's signature

Date

\*Clinical experience can include 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 specialty are also eligible.

All candidates must provide a supervisor's contact information below. INCC reserves the right to contact your supervisor to verify compliance with our clinical practice eligibility requirements.

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Supervisor's Name

Title

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Company

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E-mail

Telephone

# 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.*