Certification Renewal Forms

Use the forms in this handbook if you are mailing your application. See the Certification Renewal Requirements for detailed information on renewal eligibility criteria.

ANCC CERTIFICATION APPLICATION FORM

ANCC Certification Renewal

Staff use only: ☐ E ☐ P ☐ NE

PAYMENT

GENERAL INFORMATION Use your legal name on the application. This name will be printed on your certificate. If you are renewing with Renewal Category 8, this name must match photo identification used for examination entry. If your name has changed, submit copies of the legal documents supporting the name change.

Last Name | First Name | MI

Maiden or Other Past Legal Names | Social Security Number (optional)

Home Address

City | State | Zip/Postal Code | Country

Home Phone | Home Fax | Personal E-mail

Employer Name

Employer Address

City | State | Zip/Postal Code | Country

Work Phone | Work Fax | Work E-mail

☐ Personal Check/Money Order (payable to ANCC)

☐ Charge Card (MasterCard, VISA, or AMEX)

☐ Check here if this is an ATM/debit card. See authorization below.*

Amount Enclosed: _____

Amount to Be Charged: _____

Promotional Code (if applicable): _____

Account Number | Exp. Date

Print Name on Card | Signature

**ATM/debit card users only:* I understand and agree that, by using an ATM/debit card, I am authorizing ANCC to debit my account for the amount specified above. Further, I understand and agree that if the ATM/debit transaction fails or is declined, I am authorizing ANCC to complete the transaction as a credit card charge, if possible.

MAILING INSTRUCTIONS Print legibly using either black or blue ink, or type. **Keep a photocopy of your application for your records.** Remember to include a copy of your membership card if you are claiming a discount. Submit this application, a copy of your RN license, and payment. If your state does not issue a paper license, you should include a printout from your state board of nursing's online verification system. Mail to:

American Nurses Association
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910-3492

GENERAL INFORMATION • CONTINUED

Name of certification being renewed: _____

TYPE OF PRIMARY POSITION

- ☐ Nurse Manager
- ☐ Nurse Practitioner
- ☐ Administrator/DON/CNO/VP Nursing
- ☐ Associate/Assistant Administrator
- ☐ Educator
- ☐ Researcher
- ☐ Clinical/Staff Nurse
- ☐ Clinical Nurse Specialist
- ☐ Consultant
- ☐ Other: _____

EDUCATION (CHECK ALL THAT APPLY)

- ☐ Diploma
- ☐ Associate Degree in Nursing
- ☐ Associate Degree in Other Field
- ☐ Baccalaureate in Nursing
- ☐ Baccalaureate in Other Field
- ☐ Master's in Nursing
- ☐ Master's in Other Field
- ☐ PhD in Nursing
- ☐ PhD in Other Field
- ☐ EdD
- ☐ DNP
- ☐ DNSc
- ☐ ND
- ☐ Other: _____

RENEWAL TYPE

Maintaining an Active Certification

☐ Complete the mandatory 75 contact hours plus one or more of the 8 renewal categories.

Reactivating an Expired Certification

☐ The certification has lapsed less than two years; complete the mandatory 75 contact hours plus one or more of the 8 renewal categories.

☐ The certification has lapsed more than two years; complete the mandatory 75 contact hours plus Category 8 provided the test or portfolio is available.

SPECIAL ACCOMMODATIONS/AMERICANS WITH DISABILITIES

☐ Check here if you have a disability as defined by the Americans with Disabilities Act (ADA) and require a special accommodation. Please call 1.800.284.2378 for instructions or visit **https://www.nursingworld.org/certification/certification-policies/special-accommodations/**

LICENSURE INFORMATION All candidates must complete this section in its entirety

Required attachment: Attach a copy of your license. If your state does not issue a paper license, you should include a printout from your state board of nursing's online verification system.

☐ Check this box if your RN license is not from a state or territory of the United States.

_____

Current RN License Number

_____

State/Country Expiration Date (month/date/year)

STATEMENT OF UNDERSTANDING

I hereby apply to renew my certification by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for certification renewal. I understand that I am subject to all program requirements for certification renewal as described in this application and in the General Testing and Renewal Handbook and that certification renewal depends on successfully completing specified program requirements. If my certification is renewed, my name will be included in the official listing of certified nurses. If my certification is not renewed, I understand that my name will be removed from the official listing of certified nurses and that notification may be given by ANCC to state licensing authorities or other third parties.

By signing below, I authorize ANCC staff and the Commission on Certification to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to verify my credentials, education preparation, practice, and professional standing, and any other information included in, submitted with, or necessary for review of this application.

I expressly acknowledge and agree that information accumulated by ANCC through the certification renewal process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to schools or external researchers. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without my permission.

I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature, that I will maintain an active registered nurse license throughout the entire certification renewal period, including all subsequent renewal periods. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for certification shall be sufficient cause for ANCC to: bar me from taking this and future ANCC certification examinations or submitting a portfolio; invalidate the results of my examination or appraiser's review of my portfolio; withhold this or other ANCC certifications; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

I further understand that if my certification record is audited, I will be required to submit documentation to support the information in my application. I further understand that if I fail to timely submit supporting documentation, ANCC can: bar me from taking ANCC certification examinations or submitting a portfolio; withhold certification renewal or other certification; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

(Applications received without a signature incur a delay in processing, which will cause a delay in the review of your renewal application.)

Required Signature | Print Name | Date

MAILING LIST REFUSAL

ANCC may release mailing lists from its certification database to organizations or individuals who have information to distribute that would be beneficial to nurses or to nursing and credentialing research. If you do not wish your name and mailing address to be released for marketing purposes, please mark the decline option below.

☐ I do not wish my name and mailing address to be released for any marketing purposes.

CERTIFICATION RENEWAL AND PROFESSIONAL DEVELOPMENT RECORD

INSTRUCTIONS Effective June 1, 2016, ANCC has revised the certification renewal program. Before completing your Certification Renewal Professional Development Record, read the entire 2016 Certification Renewal Requirements Handbook and this application. ANCC has eight unique certification renewal professional development categories. After June 1, 2016, you must complete the mandatory 75 continuing education hours as described in the 2016 Certification Renewal Requirements plus one or more of the eight certification renewal categories. See the 2016 Certification Renewal Requirements for detailed instructions and specific information that may be requested if your record is randomly selected for audit.

Candidate's Name (Last, First, MI) Social Security Number (optional)

MANDATORY CONTINUING EDUCATION HOURS

EQUIVALENCIES:

1 contact hour = 60 minutes
1 CEU = 10 contact hours
1 academic quarter credit = 12.5 contact hours
1 contact hour = 0.1 CEU
1 academic semester credit = 15 contact hours
1 CME = 60 minutes or 1 contact hour

MANDATORY CONTINUING EDUCATION HOURS Complete 75 continuing education hours related to the full scope of your certification specialty. All APRN certificants (CNS and NP) are required to complete 25 continuing education hours of pharmacotherapeutics as a portion of the mandatory 75 continuing education hours in the CNS or NP certification held.

If any course title does not clearly reflect the course's relevance to your practice, include a brief description of how the course relates to your ANCC certification. Do not attach certificates of completion with this application—keep them in your files in case you are audited. Refer to ANCC Renewal Requirements at **https://www.nursingworld.org/certification/renewals/**.

MANDATORY CONTINUING EDUCATION HOURS

Title and Brief Description of Content if Title Is Generic	Date MM/DD/YY	Name of Sponsor, Provider, or Institution	ANCC Approved Yes or No meets 50% criteria	Within Your Specialty Focus Yes or No meets 51% criteria	Contact Hours Awarded	Pharm Hours Awarded
				Subtotal		

Continued on the next page

Title and Brief Description of Content if Title Is Generic	Date MM/DD/YY	Name of Sponsor, Provider, or Institution	ANCC Approved Yes or No meets 50% criteria	Within Your Specialty Focus Yes or No meets 51% criteria	Contact Hours Awarded	Pharm Hours Awarded
				Subtotal		
				Grand Total		

CERTIFICATION RENEWAL AND PROFESSIONAL DEVELOPMENT RECORD

INSTRUCTIONS Effective June 1, 2016, after completing the 75 Mandatory Continuing Education Hours, you can fulfill one or more of the eight renewal categories.

RENEWAL CATEGORY 1: CONTINUING EDUCATION HOURS Complete 75 continuing education hours in your certification specialty. See the 2016 Certification Renewal Requirements for the full details regarding Renewal Category 1 Continuing Education Hours.

If any course title does not clearly reflect the course's relevance to your practice, include a brief description of how the course relates to your ANCC certification.

Do not attach certificates of completion with this application—keep them in your files in case you are audited. Refer to ANCC Renewal Requirements at **https://www.nursingworld.org/certification/renewals/**

RENEWAL CATEGORY 1: CONTINUING EDUCATION HOURS

EQUIVALENCIES:

1 contact hour = 60 minutes
1 CEU = 10 contact hours
1 academic quarter credit = 12.5 contact hours
1 contact hour = 0.1 CEU
1 academic semester credit = 15 contact hours
1 CME = 60 minutes or 1 contact hour

RENEWAL CATEGORY 1: CONTINUING EDUCATION HOURS

Title and Brief Description of Content if Title Is Generic	Date MM/DD/YY	Name of Sponsor, Provider, or Institution	ANCC Approved Yes or No meets 50% criteria	Within Your Specialty Focus Yes or No meets 51% criteria	Contact Hours Awarded	Pharm Hours Awarded
				Subtotal		
				Continued on the next page		

Title and Brief Description of Content if Title Is Generic	Date MM/DD/YY	Name of Sponsor, Provider, or Institution	ANCC Approved Yes or No meets 50% criteria	Within Your Specialty Focus Yes or No meets 51% criteria	Contact Hours Awarded	Pharm Hours Awarded
				Subtotal		
				Grand Total		

RENEWAL CATEGORY 2: ACADEMIC CREDITS Complete either five semester credits or six quarter credits of academic courses in your certification specialty. See Certification Renewal Requirements for specific information that may be requested for audit.

Subject/Title	Date	Name of Sponsor, Provider, or Institution	Within Your Specialty Focus Yes or No	Academic Credits

RENEWAL CATEGORY 3: PRESENTATIONS One or more presentations totaling five clock hours in the certification specialty. You may not use lectures that are required by your job. The presentations may not be repeated. See the 2016 Certification Renewal Requirements for more details about this category and for specific information that may be requested for audit.

Subject/Title (Must be in your specialty area)	Date	Name of Sponsor, Provider, or Institution	Clock Hours	Audience

RENEWAL CATEGORY 4: EVIDENCE-BASED PRACTICE OR QUALITY IMPROVEMENT PROJECT OR PUBLICATION OR RESEARCH
You can complete one or more of these options to fulfill this renewal category. If using this option, please indicate which of the four sub options you are completing.

RENEWAL CATEGORY 4: EVIDENCE-BASED PRACTICE PROJECT OR QUALITY IMPROVEMENT PROJECT See the 2016 Certification Renewal Requirements for more details about this category and for specific information that may be requested for audit. (If using this option, please indicate if it is an Evidence-Based Project or Quality Improvement Project.)

1. One (1) completed Evidence-Based Practice Project that demonstrates the use of a problem-solving approach using the best evidence to answer a defined question related to your certification. The project must be started and completed during the time frame of the certification renewal period.
2. One (1) completed Quality Improvement Project that demonstrates the use of a problem-solving approach using the best evidence to answer a defined question related to your certification. The project must be started and completed during the time frame of the certification renewal period.

Project Title	Indicate if Evidence-Based Project (EBP) or Quality Improvement Project (QIP)	Start and End	Project Question and Your Role in the Project

RENEWAL CATEGORY 4: PUBLICATION Complete one of these four options below. See Certification Renewal Requirements for specific information that may be requested for audit. Please indicate which of the four options below you have chosen.

1. One (1) article published in a peer-reviewed journal, or a book chapter related to your certification specialty. You must be the author, coauthor, editor, coeditor, or peer reviewer.
2. Five (5) different articles related to your certification specialty published in a non-peer-reviewed journal and/or newsletter.
3. Primary author of content related to your certification specialty utilized in e-learning and/or other media presentation.
4. Primary grant writer for a federal, state, or national organization project, and grant writing is not a primary component of your employment responsibilities. The purpose of the grant must be related to your certification specialty.

Subject/Title	Date	Name of Publication, Sponsor, Provider, or Institution

RENEWAL CATEGORY 4: RESEARCH Complete one of these four options below. See Certification Renewal Requirements for specific information that may be requested for audit. Please indicate which of the four options below you have chosen.

1. An institutional review board (IRB) research project related to your certification specialty, completed during your five-year certification period, for which you are clearly identified as one of the primary researchers, and research is not a primary component of your employment responsibilities.
2. A completed dissertation, thesis, or graduate-level scholarly project (e.g., DNP Project) related to your certification specialty.
3. Serve as a content reviewer on an IRB, dissertation, thesis, or scholarly project (e.g., DNP Project) that is not a component of your employment duties.
4. Serve as a content expert reviewer of other activities related to your certification specialty and not as a part of your employment duties (such as software, e-learning, etc.). Serving as a product reviewer for your organization is not acceptable.

Subject/Title	Date	Name of Publication, Sponsor, Provider, or Institution

RENEWAL CATEGORY 5: PRECEPTORSHIP Complete one of these two options below:

1. Complete a minimum of 120 hours as a preceptor in which you provided direct clinical supervision/teaching to students related to your certification in an academic program at the same practice level or higher.
2. Complete a minimum of 120 hours as a preceptor in which you provided clinical supervision/teaching related to your certification specialty in a formal fellowship, residency, or internship program at the same practice level or higher.

For either preceptorship option the following rules apply:

- Clinical nurse specialists and nurse practitioners must precept APRN, medical, physician assistant, or pharmacy students in an area related to their certification specialty.
- Orientation preceptor hours are not accepted.
- Preceptor hours cannot be counted toward Renewal Option 7 practice hours.
- Faculty may not utilize this category for clinical supervision of students in their educational program.

Instructions: List preceptorships below. Complete the Preceptorship Documentation Form and keep it with your records in case of audit (or obtain a signed letter from a faculty liaison that addresses everything on the Preceptorship Documentation Form. See Certification Renewal Requirements for specific information that may be requested for audit.)

Sponsoring Agency: Name of School, Health Care Facility Responsible for the Clinician	Preceptee was: RN, CNS, NP RN, CNS, NP, Medical, Pharmacy, or Physician Assistant Student	Type of Program: Academic, Internship, Fellowship, Residency	Dates of Preceptorship	Hours Completed with This Student

RENEWAL CATEGORY 6: PROFESSIONAL SERVICE Complete two or more years of volunteer service during your certification period with an international, national, state, or local health care–related organization in which your certification specialty expertise is required. **Accepted volunteer activities include serving on boards of directors, committees, editorial boards, review boards, task forces, and medical missions.** See the 2016 Certification Renewal Requirements for specific information that may be requested for audit.

Organization	Type of Service	Dates of Service

CATEGORY 7: PRACTICE HOURS Complete a minimum of 1,000 practice hours in your certification specialty through employment and/or volunteer hours. The practice hours must be completed within the five years preceding the date of your renewal application submission. **See the 2016 Certification Renewal Requirements for more details about this category and for specific information that may be requested for audit.**

By checking the box, you are attesting that the statement is true and accurate.

☐ I have met the practice hour requirements to renew this certification, by completing a minimum of 1,000 practice hours in the certification specialty in which I am seeking to renew within the five years before submitting this application.

RENEWAL CATEGORY 8: ASSESSMENT (Examination or Portfolio Resubmission) This option is only available if an examination or portfolio is available for your certification.

☐ I am renewing my certification with the mandatory 75 continuing education hours and assessment.

DEMOGRAPHIC AND EMPLOYMENT INFORMATION

1. Location of facility:
- ☐ Urban
- ☐ Rural
- ☐ Suburban
- ☐ Outside the U.S.

2. Average number of patient encounters/visits per year at your primary place of employment:
- ☐ ≤ 1,000
- ☐ 1,001–5,000
- ☐ 5,001–10,000
- ☐ 10,001–20,000
- ☐ 20,001–40,000
- ☐ 40,001–60,000
- ☐ 60,001–80,000
- ☐ 80,001–100,000
- ☐ > 100,000

3. Will you receive a monetary reward/ compensation from your employer for certification?
- ☐ Yes ☐ No

If yes:
$ _____ per hour
$ _____ per year
$ _____ one time

4. Number of individuals you supervise:
_____

5. Years of experience as an RN (round to nearest whole year):_____

6. Total years of experience in the field in which certification is desired (round to nearest whole year):
_____

7. Primary place of employment (check one):
- ☐ Ambulatory care
- ☐ Physician-managed group practice
- ☐ Home health
- ☐ Hospice
- ☐ Hospital
- ☐ Managed care
- ☐ Nurse-managed group practice
- ☐ Nursing home
- ☐ Long-term care
- ☐ Occupational health/ environmental health
- ☐ Office nursing
- ☐ Public health/community health
- ☐ School health
- ☐ School of nursing/ university/college
- ☐ Federal/military
- ☐ Other:

_____

8. Patient population/ conditions representative of your practice (check all that apply):
- ☐ Medical-Surgical
- ☐ Cardiac
- ☐ Endocrine/Diabetes
- ☐ Pulmonary
- ☐ Neurology
- ☐ Renal/Urology
- ☐ Orthopedics
- ☐ Rehabilitation
- ☐ Gerontology
- ☐ Long-Term Care
- ☐ Perinatal
- ☐ Postpartum
- ☐ Labor and Delivery
- ☐ Pediatrics
- ☐ ER
- ☐ Trauma
- ☐ Critical Care
- ☐ Psychiatric
- ☐ Other:

_____

9. Age range of your primary patient population:
- ☐ Birth–1
- ☐ 2–21
- ☐ 22–65
- ☐ 66+

10. Average number of hours worked per week:
- ☐ 8 or fewer
- ☐ 9–16
- ☐ 17–24
- ☐ 25–32
- ☐ 33–40
- ☐ > 40

11. Size of facility (total number of beds):
- ☐ N/A
- ☐ 1–100
- ☐ 101–250
- ☐ 251–500
- ☐ > 500

12. Is certification part of your employer's job performance/clinical ladder rating criteria?
- ☐ Yes ☐ No

13. How did you obtain this application?
- ☐ From ANCC website
- ☐ Mailed from ANCC
- ☐ From my school
- ☐ From my workplace
- ☐ At a trade show
- ☐ Other:

_____

14. Please check the professional organizations of which you are a member (check all that apply):

- ☐ AAACN American Academy of Ambulatory Care Nursing
- ☐ AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
- ☐ AANP American Association of Nurse Practitioners
- ☐ ANA American Nurses Association
- ☐ ANPD Association for Nursing Professional Development
- ☐ APHA American Public Health Association (Public Health Nursing Section)
- ☐ APNA American Psychiatric Nurses Association
- ☐ ASPMN American Society for Pain Management Nursing
- ☐ ATHN American Thrombosis and Hemostasis Network
- ☐ ENA Emergency Nurses Association
- ☐ GAPNA Gerontological Advanced Practice Nurses Association
- ☐ HMA Health Ministries Association
- ☐ IAFN International Association of Forensic Nurses
- ☐ ISONG International Society of Nurses in Genetics
- ☐ ISPN International Society of Psychiatric-Mental Health Nurses
- ☐ NACNS National Association of Clinical Nurse Specialists
- ☐ NGNA National Gerontological Nursing Association
- ☐ PCNA Preventive Cardiovascular Nurses Association
- ☐ RNS Rheumatology Nurses Society
- ☐ SVN Society for Vascular Nursing
- ☐ Other: _____

OTHER DEMOGRAPHIC INFORMATION

Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Sex: ☐ M ☐ F

Date of Birth: _____ (month/day/year)

Race/Ethnic Group
- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Other:

_____

CERTIFICATION RENEWAL CATEGORY 5: PRECEPTORSHIP DOCUMENTATION FORM

Please do NOT submit this page with your renewal application. Keep this form with your records in case of audit.

INSTRUCTIONS

Renewal Category 5: Preceptorship

1. Complete a minimum of 120 hours as a preceptor in which you provided direct clinical supervision/teaching to students related to your certification in an academic program at the same practice level or higher.

2. Complete a minimum of 120 hours as a preceptor in which you provided clinical supervision/teaching related to your certification specialty in a formal fellowship, residency, or internship program at the same practice level or higher.

Keep this form with your records. You will need to submit it if you are selected for audit.

Social Security Number (optional) | Last Name | First Name
MI Certification Specialty

Candidate Information: (Completed by faculty coordinating the preceptorship)

1. The individual named above has completed _____ hours of preceptorship for

Name of the educational institution and program (e.g., University of xxx, School of Nursing)

2. The dates for the preceptorship were _____ to _____

3. This preceptorship was conducted with students in a

Nursing Program:

- ☐ Clinical Nurse Specialist (Master's or DNP)
- ☐ Nurse Practitioner (Master's or DNP)
- ☐ Nurse Midwifery (Master's or DNP)
- ☐ Nurse Anesthetist (Master's or DNP)
- ☐ Undergraduate Nursing (BSN, Associate, or Diploma)
- ☐ RN-BSN Programs

Interprofessional Program:

- ☐ Medical
- ☐ Pharmacy
- ☐ Physician Assistant

Residency/Fellowship or Internship:

- ☐ Registered Nurse
- ☐ Nurse Practitioner
- ☐ Clinical Nurse Specialist
- ☐ Nurse Midwifery
- ☐ Nurse Anesthetist
- ☐ Medical
- ☐ Pharmacy
- ☐ Physician Assistant

☐ Other nursing program (specify) _____

4. The specialty area or focus of this preceptorship was _____

5. The preceptorship was held in _____
Name of the hospital/institution/facility

Faculty coordinator name, credentials, and title (please print)

Educational institution

Program name

Institution address

Phone number

I hereby attest that the information provided on this form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in denial of certification or other adverse action.

Faculty signature | Date

Note: Please return this form to the candidate.