Thank you for your interest in AACN Certification Corporation’s exams and the 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.

If you are applying as part of a group of 10 or more to sit for the **CCRN, PCCN, 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 Member</th>
<th>Nonmember</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCRN or PCCN</td>
<td>$230</td>
<td>$340</td>
</tr>
<tr>
<td>CMC or CSC</td>
<td>$125</td>
<td>$215</td>
</tr>
</tbody>
</table>

**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](www.aacn.org/certification > Preparation Tools & Handbooks).
- Eligibility and exam preparation information for the CCRN, PCCN, CMC and CSC exams is available in the corresponding exam handbook at [www.aacn.org/certification > Preparation Tools & Handbooks](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 from AACN with instructions about how to schedule your exam appointment. The email will also include the eligibility period during which you must schedule and take the exam.
- Upon receipt of your confirmation email from AACN, you will be able to promptly schedule your exam appointment by clicking the “Schedule Exam” button in your AACN customer dashboard, which will take you to the AACN Scheduling page.
  - Before choosing an exam date, you will be required to select one of two options by which to take your computer-based exam — at a PSI testing center or via live remote proctoring from your own computer/desk in a quiet, private location.
- A government-issued identification (ID) is required to gain admission to the exam. The ID must be current and include your **photograph and signature**. *No forms of military or temporary identification will be accepted.*
- For details regarding exam scheduling and taking your exam, refer to the [Certification Exam Policy Handbook](www.aacn.org/certification > Preparation Tools & Handbooks).

**Exam Results**

- Exam results will show on-screen, and a score report will be emailed to you within 24 hours after completion of computer-based exams.
- Successful candidates will be mailed their wall certificate approximately 3 to 4 weeks after 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](mailto:certification@aacn.org) or call 800-899-2226, ext. 259.
Contents

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  • Knowledge Professional Eligibility Pathway ............................................... 6
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PCCN Honor Statements
  • Direct Care Eligibility Pathway ............................................................... 8
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CMC Honor Statement ................................................................................. 10

CSC Honor Statement ................................................................................. 11

Information for Group Coordinators/Contact Persons ................................. 12

Cover Sheet for Group Application Submissions ........................................ 13

Please direct inquiries to:
AACN Certification Corporation, 27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399
800-899-2226 • Fax: 949-362-2020 • certification@aacn.org

Please include your AACN customer number with all correspondence to AACN Certification Corporation.
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:

<table>
<thead>
<tr>
<th>LEGAL NAME:</th>
<th>Number</th>
<th>Exp. Date</th>
<th>Number</th>
<th>State</th>
<th>Exp. Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td>Maiden</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HOME ADDRESS:

EMAIL:  HOME PHONE:

EMPLOYER NAME:  BUSINESS PHONE:

EMPLOYER ADDRESS:

2. AACN MEMBERSHIP

I would also like to join/renew/extend my AACN membership at this time and select member pricing for my exam fees:

(check one box only)

☐ 1-year AACN Group membership (5 or more)……………………………………$69
☐ 1-year AACN membership (Individual)……………………………………$78
☐ 2-year AACN membership (Individual)……………………………………$148
☐ 3-year AACN membership (Individual)……………………………………$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

<table>
<thead>
<tr>
<th>Exam Type</th>
<th>Group Discount Exam Fee</th>
<th>Retest Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AACN Member</td>
<td>Nonmember</td>
</tr>
<tr>
<td>Check one box only</td>
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<td></td>
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<tr>
<td>CMC or CSC</td>
<td>☐ $125</td>
<td>☐ $215</td>
</tr>
</tbody>
</table>

☐ 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) __/___ Signature ____________________________

Amount Billed $_________ Address of Payor (if different than applicant) ____________________________

☐ Please do not include my name on lists sold to other organizations.

Please complete pages 2 of application.
5. 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 (23)
  - 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)
  - Stepdown Unit (30)

- 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 (99)

- Highest Nursing Degree
  - Associate's Degree (02)
  - Bachelor's Degree (03)
  - Diploma (05)
  - Doctorate (06)
  - Master's Degree (07)
  - Other - specify below (99)

- Ethnicity
  - African American (02)
  - Asian (05)
  - Hispanic (03)
  - Native American (04)
  - Pacific Islander (06)
  - White/Non-Hispanic (01)
  - Other - specify below (99)

- 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 (99)

- 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

6. HONOR STATEMENT — 3rd page of application that must be submitted with this form.
Complete the Honor Statement for your selected exam. See pages 5 - 11.

7. 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 the 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 - Direct Care Eligibility Pathway 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed 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 during the previous 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 eligibility 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.

NONTDISCLOSURE 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: _________________________________
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 - Knowledge Professional Eligibility Pathway 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed against my RN or APRN license(s) in the future.

**Practice:** I have fulfilled the practice requirement of 1,040 hours as an RN or APRN within the previous 2 years, with 260 of those hours accrued in the most recent year preceding application, during which I applied knowledge in a way that influenced patients, nurses and/or organizations to have a positive impact on the care delivered to 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.

**Practice Verification:** Following is the contact information for my supervisor or a professional colleague (RN or physician) who can verify that I have met the practice hour eligibility requirements:

<table>
<thead>
<tr>
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You may not list yourself or a relative as your verifier.

**Audit:** I understand that my certification eligibility 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.

**NonDisclosure 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: ___________________________
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 - Tele-Critical Care Eligibility Pathway and the Certification Exam Policy Handbook.

**LICENSEURE**: 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed 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 the care of acutely/critically ill adult patients in a tele-critical care setting (behind a camera) or in a combination of tele-critical care and direct care 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 during the previous 5 years with a minimum of 2,000 hours in the care of acutely/critically ill adult patients in a tele-critical care setting (behind a camera) or in a combination of tele-critical care and direct care, with 144 of those hours accrued in the most recent year preceding application.

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:

<table>
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**AUDIT**: I understand that my certification eligibility 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.

**NONDISCLOSURE 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.

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**Applicant's Signature:**

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</table>

This application form may be photocopied and is also available online at www.aacn.org/certification.
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 - Direct Care Eligibility Pathway 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed 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 during the previous 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 for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

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<tr>
<th>Verifier's Name:</th>
<th>Facility Name:</th>
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<table>
<thead>
<tr>
<th>Verifier's Phone Number:</th>
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</table>

You may not list yourself or a relative as your verifier.

**AUDIT:** I understand that my certification eligibility 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.

**NONDISCLOSURE 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.

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</table>

This application form may be photocopied and is also available online at [www.aacn.org/certification](http://www.aacn.org/certification).
PCCN Exam Honor Statement - Knowledge Professional Pathway
Complete and submit with 2-page application on pages 3 & 4.

Please print clearly.

NAME: ____________________________  Aacen CUSTOMER #: ______________

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 - Knowledge Professional Eligibility Pathway 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed against my RN or APRN license(s) in the future.

Practice: I have fulfilled the practice requirement of 1,040 hours as an RN or APRN within the previous 2 years, with 260 of those hours accrued in the most recent year preceding application, during which I applied knowledge in a way that influenced patients, nurses and/or organizations to have a positive impact on the care delivered to acutely ill adult patients.

I confirm that my practice is not exclusively or primarily in direct patient care. 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 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: ____________________________  Facility Name: ____________________________

Last  First  MI

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 eligibility 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.

Nondisclosure 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 application form may be photocopied and is also available online at www.aacn.org/certification.
I hereby apply for the CMC subspecialty certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the CMC 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed against my RN or APRN license(s) in the future.

**CLINICAL NURSING SPECIALTY CERTIFICATION:** I hold a current clinical nursing specialty certification that meets AACN’s criteria, which includes but is not limited to being nationally-accredited (ABSNC or NCCA). If my specialty certification is conferred by an organization other than AACN Certification Corporation, I agree to submit proof of my certification with this application. I understand that I must notify AACN if my specialty certification lapses.

To which clinical nursing specialty certification will your CMC credential be tied? ____________________________________________

Attach proof of non-AACN certification, such as copy of wallet card or wall certificate, or verification letter from certifying organization; must be valid for 90 days beyond CMC application date.

**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 adult patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application. Of those 1,750 hours, 875 were in the care of adult cardiac patients.

  **OR**

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in direct care of acutely/critically ill adult patients, with 144 of those hours accrued in the most recent year preceding application. Of those 2,000 hours, 1,000 were in the care of adult cardiac 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:

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**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 eligibility 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.

**NONDISCLOSURE 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 application form may be photocopied and is also available online at www.aacn.org/certification.
I hereby apply for the CSC subspecialty certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the CSC 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 the board of nursing in the state(s) in which I am practicing and has no provisions or conditions that limit my nursing practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any provisions or conditions are placed against my RN or APRN license(s) in the future.

Clinical Nursing Specialty Certification: I hold a current clinical nursing specialty certification that meets AACN's criteria, which includes but is not limited to being nationally-accredited (ABSNC or NCCA). If my specialty certification is conferred by an organization other than AACN Certification Corporation, I agree to submit proof of my certification with this application. I understand that I must notify AACN if my specialty certification lapses.

To which clinical nursing specialty certification will your CSC credential be tied? ____________________________________________________________

Attach proof of non-AACN certification, such as copy of wallet card or wall certificate, or verification letter from certifying organization; must be valid for 90 days beyond CSC application date.

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 adult patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application. Of those 1,750 hours, 875 were in the care of adult cardiac surgery patients within the first 48 hours postoperatively.

  OR

- Practice as an RN or APRN during the previous 5 years with a minimum of 2,000 hours in direct care of acutely/critically ill adult patients, with 144 of those hours accrued in the most recent year preceding application. Of those 2,000 hours, 1,000 were in the care of adult cardiac surgery patients within the first 48 hours postoperatively.

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: ___________________________ Facility Name: ___________________________

Last   First

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 eligibility 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.

Nondisclosure 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 application form may be photocopied and is also available online at www.aacn.org/certification.
Information for Group Coordinators/Contact Persons

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:
  AACN Certification Corporation
  Attn: Margie Elmi
  27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399

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. 259.
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).

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<th>Applicant Name</th>
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Total # of applicants: (10 or more needed)

If more than 20 applicants, use additional sheet.

Total for Membership Fees $ *For group members, $69 for 1 year
Total for Exam Fees $

Total Fee Payments(s) Included: $

NOTE: Group discount applicants are eligible for computer-based testing only.
Submit cover sheet, applications and fees to:
AACN Certification Corporation
Attn: Margie Elmi
27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399