Application for Certification in HIV/AIDS Nursing (ACRN)

Candidate Information. Please print clearly.

First Name_____Middle Initial _____

Last Name_____

Suffix _____Preferred Pronouns_____

Address _____

City_____State_____Postal Code_____Country _____

Email Address _____

Day Phone _____ Other Phone _____

Current RN License Number_____License State_____Expiration Date _____

Eligibility and Background Information. Choose only one answer for each question unless otherwise directed.

A. Percent of Working Time Currently Spent in HIV/AIDS Nursing:

o Less than 25% o 25-50% o 51-75% o More than 75%

B. Primary Position:

o Clinical Nurse Specialist
o Director/Assistant Director
o Nurse Educator/Faculty Member
o Patient Educator
o Staff Nurse/Clinician
o Consultant
o Head Nurse/Manager
o Nurse Practitioner
o Sales/Marketing Industry Nursing Representative
o Other
o Counselor
o Infection Control Practitioner
o Nurse Researcher

C. Area of Professional HIV/AIDS Emphasis:

o Adult o Pediatrics o Both Adult and Pediatrics

D. Primary Practice Setting:

o Clinical Trial Group
o Forensic Setting (jail, prison)
o Hospice
o Inpatient: Teaching Hospital
o Outpatient/Ambulatory
o Public/Community Health
o Other
o Community-Based Organization
o HIV Testing Center
o Inpatient: Community Hospital
o Inpatient: University Affiliated Hospital
o Primary Prevention Program
o School of Nursing
o Family Planning/STD
o Home Care
o Inpatient: Non-teaching Hospital
o Long-term Care Facility
o Private/Group Practice/Physician's Office
o Substance Abuse Treatment Center

E. Experience in HIV/AIDS Nursing:

o Less than 2 years o 2 years o 3-6 years o 7-10 years o More than 10 years

F. Employment Status:

o Full-Time o Part-Time o Retired o Unemployed

G. Primary Practice Location:

o Rural o Suburban o Urban (less than 1 million population)
o Mixed o Not applicable o Urban (more than 1 million population)

Application for Certification in HIV/AIDS Nursing (ACRN)

H. Highest Academic Level:

- ○ Associate Degree, Nursing
- ○ Associate Degree, Other
- ○ Baccalaureate, Nursing
- ○ Baccalaureate, Other
- ○ Diploma in Nursing
- ○ Diploma/Certificate, Other
- ○ Doctorate in Nursing
- ○ Doctorate, Other
- ○ Master's in Nursing
- ○ Master's Degree, Other
- ○ Other _

I. Other Certifications Held: (Choose all that apply)

- ○ CCRN
- ○ CEN
- ○ CIC
- ○ CRNH
- ○ OCN
- ○ RN, C
- ○ RN, CS
- ○ None
- ○ Other ___

J. Where did you hear about the Certification in HIV/AIDS Nursing Program? (Choose all that apply)

- ○ ANAC Annual Conference
- ○ ANAC Chapter
- ○ ANAC Mailing
- ○ Colleagues
- ○ JANAC
- ○ Other Journal
- ○ Other _

K. Are you currently a member of ANAC/CANAC?

○ No ○ Yes *If yes, please indicate Membership Number* _____

L. Are you currently or have you been certified in HIV/AIDS Nursing?

○ No ○ Yes *If yes, please supply certification expiration date*_____

Optional Information

Race ○ African American ○ Asian ○ Hispanic ○ White ○ Native American ○ Other

Age Range ○ Under 25 ○ 25-29 ○ 30-39 ○ 40-49 ○ 50-59 ○ 60+

Gender ○ Male ○ Female ○ Transgender ○ Non-binary ○ Prefer not to answer

Candidate Signature

I have read and understand the requirements for candidate eligibility. I affirm that all statements given on this application are true and correct to the best of my knowledge and that the HANCB is hereby authorized to contact any organization or individual listed hereon to verify my education and licensure history.

Candidate Signature:_____ **Date:** _____

Payment Options

Certification Fee, ANAC/CANAC Member: $250

Certification Fee, Non-ANAC/CANAC Member: $350

*Discounts will be deducted where applicable.

Payment can be made online via the HANCB website.

Note you do not need to have a PayPal account – you can check out as a guest.

Alternatively, HANCB now utilizes the secured third-party platform BILL.com for invoicing and collecting payments.

You can be invoiced for your certification fee by providing the following information:

Name _____

Address _____

Phone Number _____

Email address for invoice _____

Application for Certification in HIV/AIDS Nursing (ACRN): Supervisor/Colleague Verification

Please print clearly.

Candidate Name: _____

Job Title: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Postal Code: _____ Country: _____

Supervisor/Colleague Name: _____

Job Title: _____

Email Address: _____

Primary Phone: _____ Alternate Phone: _____

Give brief details of the above candidate's job role and experience:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

By my signature below, I verify that the above-named candidate for the Specialty Certification in HIV/AIDS Nursing Practice has a minimum of 2 years of HIV/AIDS nursing experience.

Name: _____

Signature: _____

Date: _____

Email completed form to hancb@anacnet.org