AACRN RECERTIFICATION APPLICATION FORM

Last Name		**First name**	
Address		**City, State, Zip Code**	
Home Phone		**Work Phone**	
Fax		**Email**	

AACRN Information		**Registered Nurse Information**		
Year of Initial Certification		**State of Licensure**		
Year of Last Recertification		**RN License Number**		
AACRN Certificate Number		**RN License Expiration Date**		
		Is your RN license in good standing in all jurisdictions in which you are currently licensed as a RN?	❑ **Yes**	❑ **No** **Please explain on separate sheet of paper**
		During the past four years, has any action been taken against your RN license?	❑ **Yes** **Please explain on a separate sheet of paper**	❑ **No**

Mail completed application form with appropriate fee to:

HANCB Recertification
11230 Cleveland Ave NW #986
Uniontown, OH 44685

Recertification Fee, ANAC Member: $300
Recertification Fee, Non-ANAC Member: $400
Late Fee: $50 (all applications postmarked after expiration date will be audited; applications postmarked more than 30 days after expiration date will not be accepted)

Background Information:

Directions: Please complete the following information to allow us to describe the group of nurses who are certified in HIV/AIDS nursing. Please mark directly on this application.

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

- ❍ Less than 25%
- ❍ 25-50%
- ❍ 51-75%
- ❍ more than 75%

B. Primary Position (Darken only one response)

- ❍ Staff nurse/clinician
- ❍ Head Nurse/Nurse Manager
- ❍ Nurse Case Manager/Coordinator
- ❍ Nurse Practitioner
- ❍ Clinical Nurse Specialist
- ❍ Patient Educator
- ❍ Nurse Educator/Faculty Member
- ❍ Director/Assistant Director
- ❍ Nurse Researcher
- ❍ Infection Control Practitioner
- ❍ Consultant
- ❍ Sales/Marketing/Industry: Nursing Rep
- ❍ Counselor
- ❍ Other

C. Area of Professional HIV/AIDS Emphasis

- ❍ Adult
- ❍ Pediatrics
- ❍ Both adult and pediatrics

D. Primary Practice Setting (Darken only one response)

- ❍ Inpatient: community hospital
- ❍ Inpatient: university affiliated hospital
- ❍ Outpatient/ambulatory care
- ❍ Public/community health
- ❍ Hospice
- ❍ Home Care
- ❍ School of Nursing
- ❍ Private/Group Practice
- ❍ Physician's office
- ❍ Substance Abuse Treatment Center
- ❍ Long-term Care Facility
- ❍ Forensic Setting (jail, prison)
- ❍ Community-Based Organization
- ❍ HIV Testing Center
- ❍ Primary Prevention Program
- ❍ Clinical Trial Group
- ❍ Family Planning/STD
- ❍ Other

E. Experience in HIV/AIDS Nursing

- ❍ Less than 2 years
- ❍ 2 years
- ❍ 3-6 years
- ❍ 7-10 years
- ❍ 11-15 years
- ❍ more than 16 years

Background Information (continued):

F. Employment Status

- ❍ Full-time
- ❍ Part-time
- ❍ Unemployed
- ❍ Retired

G. Primary Practice Location

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

H. Highest Academic Level Earned

- ❍ Master's in Nursing
- ❍ Master's, Other
- ❍ Doctorate in Nursing
- ❍ Doctorate, Other
- ❍ Other

I. Other Certifications Held (Darken ALL that apply)

- ❍ None
- ❍ CNS (state nursing board)
- ❍ APRN (state nursing board)
- ❍ ACRN
- ❍ OCN
- ❍ CIC
- ❍ CCRN
- ❍ CEN
- ❍ CRNH
- ❍ NP-C (AANP)
- ❍ BC (ANCC)
- ❍ AAHIVS (AAHIVM)
- ❍ Other

J. Are you currently a member of ANAC?

- ❍ No
- ❍ Yes
  If yes, please provide current membership number
  _____

OPTIONAL INFORMATION:

Race/Ethnicity

- African American
- Asian/Pacific Islander
- Hispanic/Latino/Latina
- Native American
- White
- Other

Age Range:

- Under 25
- 25-29
- 30-39
- 40-49
- 50-59
- 60 or older

Gender:

- Female
- Male
- Transgender

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 continuing education or licensure history.

Signature of AACRN_____

Date_____

CREDIT CARD PAYMENT

If you want to charge your recertification fee on your credit card, please provide all of the following information:

Name (as it appears on the card)

_____

Address (as it appears on the statement)

_____

_____

Charge my credit card for the total fee of
$_____

Card Type:

- **VISA**
- **MasterCard**

Expiration Date (month/year): | _____ |/| _____|

CVV#_____

Card Number _____

Signature: _____

Category I-HIV/AIDS Nursing Continuing Education: 45 hours minimum. All hours must be accredited by a state board of nursing, ANCC, AANP, or ANAC. 50 minutes=1 CEP. If audited, photocopy of certificate including name, date of attendance, accrediting agency, title of course, and number of contact hours granted is required.

Course Title	Date	Hours	HIV/AIDS (Y/N)	Accredited By (SBN/ANCC/AANP/ ANAC)
TOTAL				

Category II-Academic Courses: 15 hours maximum. Formal academic courses which address the biopsychosocial knowledge required to practice advanced HIV/AIDS nursing offered by an accredited college or university. Courses must have clear applicability to HIV/AIDS practice. Pre-requisite nursing education and general education courses are not acceptable. 1 semester hour=15 CEPs; 1 quarter hour=10 CEPs; 1 trimester hour=12 CEPs. Photocopy of formal transcript or grade report is required, course description or syllabus may be required to verify course content.

Course Title	Provider	Credit Type/Hours (semester/trimester /quarter)	Course Dates	Hours
TOTAL				

Category III-AIDS Education and Training Center (AETC) Clinical Practicum: 20 hours maximum. 50 minutes of clinical or classroom time=1 CEP. If audited, letter from course director including name, date of attendance, title of course, and number of clinical contact hours completed is required.

Course Title	Date	Hours	Total CEPs	Verification (Y/N)
TOTAL				

Category IV-Continuing Medical Education: 45 hours maximum. All courses must be accredited by state medical associations,

American Medical Association, American Academy of HIV Medicine, International AIDS Society, Infectious Disease Society of America, and other specialty medical associations or the international equivalents. All courses must be clearly related to advanced HIV/AIDS nursing practice. If audited, a photocopy of certificate including name, date, title of course, accrediting agency, and number of contact hours granted is required.

Course Title	Date	Hours	HIV/AIDS (Y/N)	Accredited By (AMA/IDSA/ AAHIVM/IAS)
TOTAL				

Category V-Professional Activities: 20 hours maximum. Includes subcategories of professional activities, including publications, presentations, and grant writing activities directly related to HIV/AIDS nursing. Copies of articles and chapters or a letter of acceptance from the publisher are required for verification of publications. Brochures, program announcements, or written statements from sponsors or program planners are required for verification of presentations. Copies of grant submission letters or notice of funding are required for verification of grant writing activities. See Appendix A for maximum hours allowed in each subcategory.

Professional Activity	Date	Hours	HIV/AIDS (Y/N)	Verification (Y/N)
TOTAL				

Category VI-Volunteer Activities: 15 hours maximum. Includes voluntary leadership activities with established HIV/AIDS volunteer services or non-profit organizations. Activities include membership on national, local, or international taskforces or committees, participation on ANAC, HANCB, JANAC, or HIV/AIDS conference planning committee, or participation in HANCB item review sessions. Letters verifying activities, dates and hours served will be required from the agency or organization to verify voluntary activities.

Volunteer Activity	Date	Hours	HIV/AIDS (Y/N)	Verification (Y/N)
TOTAL				