



**Application for
Advanced Certification Examination in HIV/AIDS Nursing**

Candidate Information. Please print clearly.

First Name _____ Middle Initial _____

Last Name _____ Suffix _____

Address _____

City _____ State _____ Postal Code _____ Country _____

Email Address _____

Day Phone (____) _____ - _____ Evening 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:

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

B. Primary Position:

- | | | |
|---|---|--|
| <input type="radio"/> Staff Nurse/Clinician | <input type="radio"/> Head Nurse/Manager | <input type="radio"/> Nurse Practitioner |
| <input type="radio"/> Clinical Nurse Specialist | <input type="radio"/> Patient Educator | <input type="radio"/> Nurse Educator/Faculty Member |
| <input type="radio"/> Director/Assistant Director | <input type="radio"/> Nurse Researcher | <input type="radio"/> Infection Control Practitioner |
| <input type="radio"/> Consultant | <input type="radio"/> Sales/Marketing Industry Nursing Representative | |
| <input type="radio"/> Counselor | <input type="radio"/> Other | |

C. Area of Professional HIV/AIDS Emphasis:

- Adult Pediatrics Both Adult and Pediatrics

D. Primary Practice Setting:

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

E. Experience in HIV/AIDS Nursing:

- 2000 Hours Less than 2 years 2 years 3-6 years 7-10 years 10+ years

F. Employment Status:

- Full-Time Part-Time Retired Unemployed

G. Primary Practice Location:

- | | | |
|-----------------------------|--------------------------------------|--|
| <input type="radio"/> Rural | <input type="radio"/> Suburban | <input type="radio"/> Urban (less than 1 million population) |
| <input type="radio"/> Mixed | <input type="radio"/> Not applicable | <input type="radio"/> Urban (more than 1 million population) |



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H. Highest Academic Level:

- Master of Science with Nursing concentration (MS)
Master of Science in Nursing (MSN)
Master of Nursing (MN)
Master of Arts in Nursing (MA)
Master of Public Health (MPH)
Nursing Doctor (ND)
Doctor of Nursing Science (DSNC or SDN)
Doctor of Philosophy in Nursing (PhD)
Other

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

- None
CIC
CEN
BC
AOCN
CCNS
Hospice
Other

J. Are you currently a member of ANAC? No Yes If yes, indicate Membership Number

K. Do you/will you receive a monetary reward for certification? No Yes

L. Is certification part of the job/performance/clinical ladder rating criteria? No Yes

M. Are you currently or have you ever been certified in Advanced HIV/AIDS Nursing (AACRN)?

- No
Yes If yes, please supply expiration date

N. Are you currently or have you been certified as an HIV/AIDS Certified Registered Nurse (ACRN)?

- No
Yes If yes, please supply expiration date

O. Have you taken this exam before? No Yes Date Name

P. Where Did You Hear About the Certification in HIV/AIDS Nursing Program? (Choose all that apply)

- ANAC Mailing
ANAC Chapter
Colleagues
ANAC Conference
JANAC
Other Journal
Other

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

Experience Validation

By my signature below, I verify that the above-named candidate for the Specialty Certification Examination in Advanced HIV/AIDS Nursing Practice has a minimum of 2,000 hours of HIV/AIDS nursing experience within the five years prior to application.

Name: Relationship to Candidate:

Signature: Phone Number: () -

Candidate Signature

I have read and understand the requirements for candidate eligibility and the cancellation, rescheduling and no show policies. 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:

Credit Card Payment If you want to charge your application fee to your credit card, provide all of the following information.

Name (as it appears on your card):

Billing Address

Card Type: Visa MasterCard American Express Discover

Card Number: Expiration Date: CVV: Amount to Charge: \$

Signature: Date: