



Application for Advanced Certification in HIV/AIDS Nursing (AACRN)

Candidate Information. Please print clearly.

First Name _____ Middle Initial _____

Last Name _____ Suffix _____

Preferred Pronouns _____

Address _____

City _____ State _____ Postal Code _____ Country _____

Email Address _____

Primary Phone (____) _____ - _____ Alternate 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"/> Case Manager/Coordinator | <input type="radio"/> Clinical Nurse Specialist | <input type="radio"/> Counselor |
| <input type="radio"/> Consultant | <input type="radio"/> Director/Assistant Director | <input type="radio"/> Head Nurse/Manager |
| <input type="radio"/> Infection Control Practitioner | <input type="radio"/> Nurse Educator/Faculty Member | <input type="radio"/> Nurse Practitioner |
| <input type="radio"/> Nurse Researcher | <input type="radio"/> Patient Educator | <input type="radio"/> Sales/Marketing Industry Nursing Representative |
| <input type="radio"/> Staff Nurse/Clinician | <input type="radio"/> Other _____ | |

C. Area of Professional HIV/AIDS Emphasis:

- Adult Pediatrics Both Adult and Pediatrics

D. Primary Practice Setting:

- | | | |
|---|---|---|
| <input type="radio"/> Clinical Trial Group | <input type="radio"/> Community-Based Organization | <input type="radio"/> Family Planning/STD |
| <input type="radio"/> Forensic Setting (jail, prison) | <input type="radio"/> HIV Testing Center | <input type="radio"/> Home Care |
| <input type="radio"/> Hospice | <input type="radio"/> Inpatient: Community Hospital | <input type="radio"/> Inpatient: Non-teaching Hospital |
| <input type="radio"/> Inpatient: Teaching Hospital | <input type="radio"/> Inpatient: University Affiliated Hospital | <input type="radio"/> Long-term Care Facility |
| <input type="radio"/> Outpatient/Ambulatory | <input type="radio"/> Primary Prevention Program | <input type="radio"/> Private/Group Practice/Physician's Office |
| <input type="radio"/> Public/Community Health | <input type="radio"/> School of Nursing | <input type="radio"/> Substance Abuse Treatment Center |
| <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"/> Mixed | <input type="radio"/> Rural | <input type="radio"/> Suburban |
| <input type="radio"/> Urban (less than 1 million population) | <input type="radio"/> Urban (more than 1 million population) | <input type="radio"/> Not applicable |



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H. Highest Academic Level:

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

I. Other certifications held: (Choose all that apply)

- AOCN
- BC
- CCNS
- CEN
- Hospice
- None
- 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 ever been, certified as an HIV/AIDS Registered Nurse (ACRN)?

No Yes *If yes, please supply expiration date* _____/_____/_____

O. Did you take any organized review courses prior to starting the Certification process?

No Yes Date _____ Location _____

P. 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 _____

Optional Information

Race

- African American
- Asian
- Hispanic
- Native American
- White
- Other

Age Range

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

Gender

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

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. 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: _____



Application for Advanced Certification in HIV/AIDS Nursing (AACRN)

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: ____