Application for
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 __________________________________________________________________

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

C. Area of Professional HIV/AIDS Emphasis:
   ○ Adult
   ○ Pediatrics
   ○ Both Adult and Pediatrics

D. Primary Practice Setting:
   ○ Inpatient: Community Hospital
   ○ Inpatient: University Affiliated Hospital
   ○ Inpatient: Non-teaching Hospital
   ○ Outpatient/Ambulatory
   ○ 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
   ○ More than 10 years

F. Employment Status:
   ○ Full-Time
   ○ Part-Time
   ○ Retired
   ○ Unemployed

G. Primary Practice Location:
   ○ Rural
   ○ Suburban
   ○ Mixed
   ○ Not applicable
   ○ Urban (less than 1 million population)
   ○ Urban (more than 1 million population)
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H. Highest Academic Level:
○ Diploma/Certificate, Nursing
○ Baccalaureate, Nursing
○ Masters Degree, Nursing
○ Doctorate, Other
○ Diploma/Certificate, Other
○ Baccalaureate, Other
○ Masters Degree, Other
○ Doctorate, Nursing
○ Associate Degree, Nursing
○ Associate Degree, Other
○ Other ___________________

I. Other Certifications Held: (Choose all that apply)
○ None
○ R.N.,C
○ OCN
○ CIC
○ CCRN
○ CRNH
○ RN, CS
○ Other _______________

J. Where Did You Hear About the Certification in HIV/AIDS Nursing Program? (Choose all that apply)
○ ANAC Mailing
○ ANAC Chapter
○ Colleagues
○ ANAC Annual Conference
○ JANAC
○ Other Journal
○ Other _________________

K. Are you currently a member of ANAC?
○ 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 _____/_____

M. Have you taken this exam before?
○ No
○ Yes  Date_____ / _____ Name ___________________

N. Did you take the online Practice Exam prior to taking the Certification Examination?
○ No
○ Yes

O. Did you take any organized review courses prior to taking the Certification Examination?
○ No
○ Yes  Date_____ / _____ Location ___________________

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

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: ___________________

This form is for fax or US mail only. For security purposes please do not scan or email this form. Contact HANCB at +1(800) 260-6780.