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 (____) _______ - _____________ 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:
○ Clinical Nurse Specialist  ○ Consultant  ○ Counselor
○ Director/Assistant Director  ○ Head Nurse/Manager  ○ Infection Control Practitioner
○ Nurse Educator/Faculty Member  ○ Nurse Practitioner  ○ Nurse Researcher
○ Patient Educator  ○ Sales/Marketing Industry Nursing Representative
○ Staff Nurse/Clinician  ○ Other

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

D. Primary Practice Setting:
○ Clinical Trial Group  ○ Community-Based Organization  ○ Family Planning/STD
○ Forensic Setting (jail, prison)  ○ HIV Testing Center  ○ Home Care
○ Hospice  ○ Inpatient: Community Hospital  ○ Inpatient: Non-teaching Hospital
○ Inpatient: Teaching Hospital  ○ Inpatient: University Affiliated Hospital  ○ Long-term Care Facility
○ Outpatient/Ambulatory  ○ Primary Prevention Program  ○ Private/Group Practice/Physician’s Office
○ Public/Community Health  ○ School of Nursing  ○ Substance Abuse Treatment Center
○ 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  ○ Urban (less than 1 million population)
○ Mixed  ○ Not applicable  ○ Urban (more than 1 million population)
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H. Highest Academic Level:
- Associate Degree, Nursing
- Baccalaureate, Other
- Doctorate in Nursing
- Master’s Degree, Other
- Associate Degree, Other
- Diploma in Nursing
- Doctorate, Other
- Other
- Baccalaureate, Nursing
- Diploma/Certificate, Other
- Master’s in Nursing

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
- JANAC
- ANAC Mailing
- 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. Did you take any organized review courses prior to starting the Certification process?
- 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
- 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: ______________

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: $\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ______________
Signature: __________________________ Date: ______________

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