EXAM APPLICATIONS FOR GROUP DISCOUNT PROGRAM

The following information applies to individuals submitting their AACN certification exam application in the same envelope along with those of at least nine (9) other exam applicants.

Thank you for your interest in AACN Certification Corporation’s exams and the group discount program!

If you are applying as part of a group of 10 or more to sit for the CCRN, PCCN, CCRN-E, CMC or CSC exam via computer-based testing, please use the application on the following pages. Discounted group rates are as follows:

<table>
<thead>
<tr>
<th>Exam</th>
<th>AACN Members</th>
<th>Nonmembers</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCRN/CCRN-E</td>
<td>$205</td>
<td>$310</td>
</tr>
<tr>
<td>PCCN</td>
<td>$155</td>
<td>$235</td>
</tr>
<tr>
<td>CMC/CSC</td>
<td>$125</td>
<td>$170</td>
</tr>
<tr>
<td>*CCNS/ACNPC</td>
<td>$225</td>
<td>$325</td>
</tr>
</tbody>
</table>

*If you are applying as part of a group to sit for the CCNS or ACNPC exam via computer-based testing, please use the application found in the CCNS Exam Handbook or ACNPC Exam Handbook at www.certcorp.org > Documents and Handbooks. Include the CCNS or ACNPC discounted group rate.

APPLICANTS

- General policies for all AACN certification exam programs including day of exam rules, recognition and use of credentials, obtaining a duplicate score report and name or address changes are available in the Certification Exam Policy Handbook at www.certcorp.org > Documents and Handbooks.
- Review the handbook for your selected exam prior to applying for the exam and retain a copy for reference.
- Complete the 2-page application and 1-page honor statement in this handbook for your selected exam.
- Provide your completed exam application and fee to your group coordinator/contact person.

AFTER APPLICATION IS SUBMITTED

- Once your application has been processed, you will receive an email and postcard from our testing service, Applied Measurement Professionals, Inc. (AMP), confirming your registration.
- Your email and postcard will include exam scheduling information and the 90-day window during which you must schedule and sit for your computer-based exam.
- Upon receipt of your postcard or email, promptly call or go online to schedule your testing appointment.
- For admission to the testing center, you must provide your testing ID number and present 2 pieces of identification, 1 with a current photograph.
- Testing is offered 6 days per week, twice daily at more than 175 AMP testing centers across the U.S. Locate your nearest computer-based testing center at www.goAMP.com.

EXAM RESULTS

- Results of your exam will be provided upon completion of the computer-based exam.
- Those who pass the exam will also receive a wall certificate by mail within 3 to 4 weeks of testing.

GROUP COORDINATORS/CONTACT PERSONS

Please refer to pages 10 and 11 for details about requesting the group discount and mailing of applications.

Thank you for your commitment to nursing certification.

For questions please contact us at certification@aacn.org or call (800) 899-2226, ext. 265.
GROUP DISCOUNT EXAM APPLICATION

For use only by individuals submitting their exam application in the same envelope
with at least 9 other applicants.

1. REGISTRATION INFORMATION

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.
LEGAL NAME AS IT APPEARS ON YOUR GOVERNMENT-ISSUED ID CARD IS REQUIRED FOR EXAM.

<table>
<thead>
<tr>
<th>Aacen Customer</th>
<th>RN/APRN License</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEGAL NAME</td>
<td></td>
</tr>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Number</td>
<td>Exp. Date</td>
</tr>
<tr>
<td>Number</td>
<td>State</td>
</tr>
<tr>
<td>HOME ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>State</td>
</tr>
<tr>
<td>INSTITUTION NAME</td>
<td>CITY OF</td>
</tr>
<tr>
<td>INSTITUTION ADDRESS</td>
<td>State</td>
</tr>
<tr>
<td>PREFERRED EMAIL</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>State</td>
</tr>
<tr>
<td>HOME PHONE</td>
<td></td>
</tr>
</tbody>
</table>

2. AACN MEMBERSHIP

I would also like to join/renew my Aacen membership at this time and select member pricing for my exam fees: (check only one box)

☐ 1-year Aacen membership...............................................................$69 (special group program rate, regular rate $78)
☐ 2-year Aacen membership...............................................................$148
☐ 3-year Aacen membership...............................................................$200

3. EXAM FOR WHICH YOU ARE APPLYING

☐ Check this box if you've attached a request and supporting documentation for special testing accommodations.

4. PAYMENT INFORMATION

☐ Check or money order attached – payable to Aacen Certification Corporation, U.S. funds only.
Bill my credit card ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover Card

<table>
<thead>
<tr>
<th>Credit Card #</th>
<th>Exp. Date (mm/yy)</th>
</tr>
</thead>
</table>

Name on Card ___________________________ Signature ___________________________

Amount Billed $_________ Address of Payor (if different than applicant)________________________

☐ Please do not include my name on lists sold to other organizations. Please complete page 2 of application.
GROUP DISCOUNT EXAM APPLICATION

PRINTED NAME

6. DEMOGRAPHIC INFORMATION (Check one box in each category.) Information is used for statistical purposes and may be used in eligibility determination.

Primary Area Employed
- Acute Hemodialysis Unit (21)
- Burn Unit (13)
- Cardiac Rehabilitation (26)
- Cardiac Surgery/OR (36)
- Cardiovascular/Surg, ICU (09)
- Catheterization Lab (22)
- Combined Adult/Ped ICU (23)
- Combined ICU/CCU (01)
- Coronary Care Unit, ICU (03)
- Corporate Industry (24)
- Crit. Care Transport/Flight (17)
- Emergency Dept (12)
- General Med/Surg Floor (18)
- Home Care (25)
- Intensive Care Unit (ICU) (02)
- Interventional Cardiology (31)
- Long-Term Care (27)
- Medical Cardiology (34)
- Medical ICU (04)
- Med, Surg, ICU (35)
- Neonatal ICU (06)
- Neuro/Neurosurgical ICU (10)
- Oncology Unit (19)
- Operating Room (15)
- Outpatient Clinic (29)
- Pediatric ICU (05)
- Private Practice (32)
- Progressive Care Unit (16)
- Recovery Room/PACU (14)
- Respiratory ICU (08)
- Stepdown Unit (30)
- Subacute Care (28)
- Surgical ICU (07)
- Tele-ICU (37)
- Telemetry (20)
- Trauma Unit (11)
- Other - specify below

Primary Position Held
- Academic Faculty (07)
- Acute Care Nurse Practitioner (09)
- Administrator/V.P. (43)
- Bedside/Staff Nurse (01)
- Clinical Director (04)
- Clinical Nurse Specialist (08)
- Corporate Executive (11)
- Elective Official (12)
- Inservice/Staff Dev. Instructor (06)
- Legal Nurse Consultant (39)
- Manager (03)
- Nurse Anesthetist (02)
- Nurse Educator (49)
- Nurse Midwife (13)
- Nurse Practitioner (05)
- Pharmacist (14)
- Physician (15)
- Physician Assistant (17)
- Researcher (18)
- Respiratory Therapist (19)
- Social Worker (20)
- Unit Coordinator (22)
- Other - specify below

Is English your first language?
- Yes  ☐ No

Did you graduate from nursing school in a country other than the U.S.?
- Yes  ☐ No

If yes, which country?

What year did you start practicing nursing in the U.S.?

Highest Nursing Degree
- Associate's Degree
- Bachelor's Degree
- Diploma
- Doctorate
- Master's Degree

Primary Type of Facility in Which Employed
- College/University (08)
- Community Hospital (Nonprofit) (01)
- Community Hospital (Profit) (02)
- County Hospital (07)
- HMO/Managed Care (12)
- Home Health (13)
- Military/Government Hospital (04)
- Private Industry (11)
- Registry (10)
- Self-Employed (09)
- Travel Nurse (15)
- University Med. Center (03)
- Other - specify below

Number of beds in Institution

Years experience in Nursing

Years experience in Acute/Critical Care Nursing

Date of Birth (Month/Day/Year)

7. HONOR STATEMENT - 3rd page of application that must be submitted with this form

Complete the Honor Statement for your selected exam:
- CCRN - page 5
- PCCN - page 6
- CCRN-E - page 7
- CMC - page 8
- CSC - page 9

8. SUBMIT APPLICATION

Attach Honor Statement to this application and submit with payment to your group coordinator/contact person.

NOTE: Allow 2 to 4 weeks from date received by AACN Certification Corporation for processing of exam applications submitted via the Group Discount Program.

Questions? Please visit www.certcorp.org, email certcorp@aacn.org or call us at (800) 899-2226.
CCRN EXAM APPLICATION HONOR STATEMENT

Complete and submit with 2-page application on pages 3 & 4.

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.

NAME: ____________________________________________________________

AACN CUSTOMER #: ____________

Last    First    MI

I hereby apply for CCRN certification offered by AACN Certification Corporation. I have read and understand the exam policies and eligibility requirements as documented in the Certification Exam Policy Handbook and the CCRN/PCCN Certification Exam Handbook. I acknowledge that certification depends upon successful completion of the specified requirements.

LICENSURE: I possess a current unencumbered U.S. RN or APRN license. My ____________________________ (state) RN license _______________ (number) is due to expire ____________________________ (date).

An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit the nurse's practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any disciplinary action is taken against my RN license in the future.

PRACTICE: I have fulfilled the clinical practice hour requirements of 1,750 hours of direct bedside care of acutely and/or critically ill

☐ Adult  ☐ Pediatric  ☐ Neonatal (check one only)

patients as an RN or APRN within the previous 2-year period, with 875 hours accrued in the most recent year preceding this application.

PRACTICE VERIFICATION: Following is the contact information of my clinical supervisor or a professional associate (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

VERIFIER'S NAME: ____________________________________________

FACILITY NAME: ____________________________________________

Last    First

VERIFIER'S PHONE NUMBER: ____________________________

VERIFIER'S EMAIL ADDRESS: __________________________________

You may not list yourself or a relative as your verifier.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

AUDIT: I understand that information supplied is subject to audit and failure to respond to a request for further information may be sufficient cause for AACN Certification Corporation to bar me from the exam, invalidate the results of my exam, withhold certification, revoke certification or take other appropriate action.

NON-DISCLOSURE OF EXAM CONTENT: My signature on this form indicates my agreement to keep the contents of the exam confidential and not disclose or discuss the specific exam content with anyone except AACN Certification Corporation. By complying with and enforcing this obligation, I help maintain the integrity of the AACN Certification Program and the value of its certification credentials.

To the best of my knowledge, the information contained in the application is true, complete, correct and is made in good faith. I am aware that the information acquired in the certification process may be used for statistical purposes and for evaluation of the certification program.

Applicant's Signature: ____________________________    Date: ____________________________

AUGUST 2012

This form may be photocopied and is also available online at www.certcorp.org.
PCCN EXAM APPLICATION HONOR STATEMENT

Complete and submit with 2-page application on pages 3 & 4.

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.

NAME: ___________________________ AACN CUSTOMER #: ___________________________

Last Name First Name MI

I hereby apply for PCCN certification offered by AACN Certification Corporation. I have read and understand the exam policies and eligibility requirements as documented in the Certification Exam Policy Handbook and the CCRN/PCCN Certification Exam Handbook. I acknowledge that certification depends upon successful completion of the specified requirements.

LICENSURE: I possess a current unencumbered U.S. RN or APRN license. My ___________________________ (state) RN license ___________________________ (number) is due to expire ___________________________ (date). An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit my practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any disciplinary action is taken against my RN or APRN license in the future.

PRACTICE: I have fulfilled the clinical practice hour requirements of 1,750 hours of direct bedside care of acutely ill adult patients as an RN or APRN within the previous 2-year period, with 875 hours accrued in the most recent year preceding this application.

PRACTICE VERIFICATION: Following is the contact information of my clinical supervisor or a professional associate (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

VERIFIER’S NAME: ___________________________ FACILITY NAME: ___________________________

Last Name First Name

VERIFIER’S PHONE NUMBER: ___________________________ VERIFIER’S EMAIL ADDRESS: ___________________________

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Applicant’s Signature: ___________________________ Date: ___________________________