

Examination Application

Instructions: To apply for a WOCNCB® examination, please return the completed application with all appropriate fees and documentation to:

WOCNCB® Examination
c/o Applied Measurement Professionals, Inc. (AMP)
18000 W. 105th Street
Olathe, KS 66061-7543

Within approximately six weeks of receiving your application, AMP will forward either a confirmation notice or a letter explaining why the application is being returned. You are advised to keep a copy of your completed application for your records. WOCNCB is not responsible for correspondence lost in the mail.

Section 1: Personal Information (please print using black or blue ink)

Name: _____

Date of Birth: _____ E-mail: _____

Phone #: Day _____ Evening _____

Mailing Address: (street, apt #, city, state, zip code, country)

Education: (Check Highest)

- Diploma Associate BA BS BSN MSN PhD
 NP CNS Other: (specify) _____

Practice Setting: (Check All That Apply)

- Acute Homecare Outpatient Extended
 Education Administration Research

Years in Nursing: _____ Years as a WOC Nurse: _____

Section 2: Examination Information

Indicate Quarterly Examination Cycle Desired Postmark Deadline

- | | |
|--------------------------------------------------|-------------|
| <input type="checkbox"/> January 1 – March 31 | November 15 |
| <input type="checkbox"/> April 1 – June 30 | February 15 |
| <input type="checkbox"/> July 1 – September 30 | May 15 |
| <input type="checkbox"/> October 1 – December 23 | August 15 |

Examination Fees

Indicate the appropriate fee(s). Make check or money order payable to AMP or pay by credit card.

1 Specialty	\$300	3 Specialties	\$400
2 Specialties	\$350	4 Specialties	\$450

This new schedule also applies for any combination of recertification pathways; by exam and/or Professional Growth Program; and/or combination of specialty exams (i.e., wound, ostomy, continence and/or foot/nail certification).

See page 4 for late application fees.

If payment is by credit card, complete the following:

- VISA MasterCard

Card #: _____

Exp. Date: _____

Your name as appears on card: _____

Signature: _____

Section 3: Examination(s) for which you are applying

Indicate the examination(s) for which you are applying and your applicant status (e.g., new applicant).

Note: Complete all three sections if you are seeking the CWOCN® credential.

Certified Wound Care Nurse Examination

- New applicant
 Reapplicant – The last time I attempted this examination was: _____ / _____
mo. / yr.
 Applicant for Recertification – My last date of certification is: _____ / _____
mo. / yr.

Certified Ostomy Care Nurse Examination

- New applicant
 Reapplicant – The last time I attempted this examination was: _____ / _____
mo. / yr.
 Applicant for Recertification – My last date of certification is: _____ / _____
mo. / yr.

Certified Continence Care Nurse Examination

- New applicant
 Reapplicant – The last time I attempted this examination was: _____ / _____
mo. / yr.
 Applicant for Recertification – My last date of certification is: _____ / _____
mo. / yr.

If you are recertifying your CWOCN® credential, you must successfully complete all three examinations within two consecutive quarterly testing cycle.

Section 4: Eligibility

Initial certification:

- I am currently licensed as a Registered Nurse. (A copy of your current license must be enclosed.)

AND

- I hold a baccalaureate degree. (A copy of your diploma or transcript must be enclosed.)

AND

– choose ONE of the following to document your eligibility:

- I am a graduate of a WOC (ET) Nursing Education Program accredited by WOCN.

Year of Graduation

Program Code (see page 6 in this Handbook for a listing)
• You must apply within five (5) years of program graduation. (Effective Jan. 1, 2009)
• Skip to Section 8 if you are a program graduate.
• A copy of your certificate of completion/graduation must be enclosed.
- I am applying as a Graduate Pathway Candidate and have completed a graduate program in nursing with documentation of graduate clinical course work equivalent to two semester credits in each specialty for which certification is sought.
• Official college transcripts, Diploma, and course descriptions must be enclosed.
• Credits must directly apply to the clinical practice in the specialty for which you apply.
- I am applying as an Experiential Pathway Candidate and have 50 contact hours and 1,500 clinical experience hours over the last five years within each specialty for which certification is sought.
• Copies of diploma and certificates of completion of contact hours must be enclosed.
• Fill in sections 6 & 7 if you are an Experiential Pathway candidate.
• Complete page 19 to verify CEUs.
• CEUs must directly apply to the clinical practice in the specialty for which you apply.

Recertification of valid (non-lapsed) credentials:

- I am currently licensed as a Registered Nurse.
Program Code _____ See page 6 in this Handbook for a listing.
• A copy of your current license must be enclosed. No other documentation is required.
• Skip to Section 8 if you are a program graduate.

Recertification of lapsed credentials:

- Please fill in your eligibility at the top of Section 4, as an initial certification. The eligibility requirements are the same. However, if your credentials are lapsed more than two (2) years, effective January 1, 2009 you must apply via the Experiential Pathway.

Section 5: Special ADA Accommodation Request
 Yes (Completed forms on pages 15 and 16 must be enclosed.)

Sections 6 & 7 must be completed ONLY by Experiential Pathway candidates. If you are a WOC Education Program graduate, please skip sections 6 & 7.

Section 6: Verification of Previous Experience
Previous Employment
 List previous employers below. If you need additional space to verify other employment pertinent to your eligibility, please include an additional page.
 Not applicable to the 1,500 hours per specialty
 Employment Dates From: ___/___/___ To: ___/___/___
 Name of Employer: _____
 Address: _____
 Your Title/Position: _____

Hours Worked Per Week	×	# of Weeks	=	Total Hours
Wound _____	×	_____	=	Wound _____
Ostomy _____	×	_____	=	Ostomy _____
Continenence _____	×	_____	=	Continenence _____

Supervisor's Name: _____
 Supervisor's Phone #: _____
 Employment Dates From: ___/___/___ To: ___/___/___
 Name of Employer: _____
 Address: _____
 Your Title/Position: _____

Hours Worked Per Week	×	# of Weeks	=	Total Hours
Wound _____	×	_____	=	Wound _____
Ostomy _____	×	_____	=	Ostomy _____
Continenence _____	×	_____	=	Continenence _____

Supervisor's Name: _____
 Supervisor's Phone #: _____

Section 7: Verification of Current Experience
This section must be completed by your Medical Director, Administrative Director or immediate supervisor.
 I am the Medical Director, Administrative Director or immediate supervisor of the individual who has completed this application for the WOCNCB® Examination(s). I hereby certify that the applicant has completed at least 1,500 hours clinical experience in wound, ostomy and/or continence practice in the last five years for each specialty certification being sought (4,500 hours if all three specialties are being sought). Further, 375 hours must have occurred within the past **one** year prior to application.

Present Employment

Hours Worked Per Week	×	# of Weeks	=	Total Hours in Last 5 Years
Wound _____	×	_____	=	Wound _____
Ostomy _____	×	_____	=	Ostomy _____
Continenence _____	×	_____	=	Continenence _____

Plus Section 6 Total Hours _____
 Grand Total in the Last 5 Years _____

Employment Dates From: ___/___/___ To: ___/___/___
 Hospital or Company Name: _____
 Address: _____
 Signature: _____
 Printed Name: _____
 Title: _____
 Phone #: _____

Section 8: Referral Database and Information

The WOCNCB® would like to include you in a certified nurse referral database on our Web site, www.wocncb.org. We would like permission to include your name, address, telephone number and e-mail in this database. This information will not be sold for industry marketing purposes.

I agree
 I do not agree

I am interested in clinical, professional practice or WOC educational information. Please send me information on the Wound Ostomy and Continence Nurses Society.

Yes
 No

Section 9: Authorization of Name and Score Release
(This section to be completed only by graduates of WOCN accredited WOC Nursing Education Programs.)

WOCNCB® reports examination statistics to the WOCN Accredited Nursing Education Program indicated on this application form. Quality education is the primary goal of these programs. Your permission to release your name and test scores to the program you attended will provide the statistics they need to continually improve their program.

I give my permission to release my name and test scores to the WOCN accredited WOC Nursing Education Program indicated on this application form.

Signature: _____
 Date: _____

Section 10: Signature

I certify that I have read all portions of the WOCNCB® Candidate Handbook and application. I certify that the information I have submitted in this application and the documents I have enclosed are complete and correct to the best of my knowledge and belief. I understand that if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed, not released or invalidated by the WOCNCB®. I understand that all documentation that supports my application will be kept available by me for submission to the WOCNCB® should I be requested to participate in random audits for quality assurance.

Name (please print): _____
 Signature: _____
 Date: _____



EXPERIENTIAL PATHWAY VERIFICATION OF CONTINUING EDUCATION FORM

Name _____ Date _____

1. Complete a separate form for each specialty area. Check one: Wound Ostomy Continence
2. Point calculation: 1 point for each CEU or contact hour.
3. CEUs must directly apply to the clinical practice in the specialty for which you apply.

Program Date(s)	Title of Course	Course Provider	Approved Accrediting Organization	Hours/Points
6/2005	Example: Ethics in Wound Care	County General Hospital	Ohio Nurses Association	3
			Total CEUs	