WOC NURSING CERTIFICATION BOARD

EXAMINATION APPLICATION

To apply, please return the completed application with all appropriate fees to:
WOCNCB Exam, c/o Castle Worldwide, Inc., 900 Perimeter Park Drive, Suite G - Morrisville, NC 27560
–OR– complete the online application at www.wocncb.org

Within 2-4 weeks of receiving your application, Castle Worldwide will send either a Notice to Schedule your exam(s) or request for any missing documentation. You are advised to keep a copy of your completed application for your records. WOCNCB is not responsible for correspondence lost in the mail.

GENERAL INFORMATION (PLEASE PRINT USING BLACK OR BLUE INK)

First Name MI Last Name

Former name(s) if changed within past 5 years

Address: Address 2:

City State/Province: ZIP/Postal Code: Country:

Phone Number – Work Phone Number – Home or Cell

Primary Email Address

Practice Setting: *(check all that apply)*

☐ Acute ☐ Homecare ☐ Outpatient ☐ LTC/Nursing home
☐ LTAC ☐ Education ☐ Administration ☐ Research ☐ Industry
☐ Self-employed ☐ Other _____(specify)

EXAMINATION TYPE

Indicate the examination(s) for which you are applying and your applicant status. NOTE: Candidates must successfully complete all three exams within the 12-month eligibility period in order to earn the tri-specialty CWOCN® credential.

☐ Certified Wound Care Nurse (CWCN®)
- ☐ Initial Exam
  Applying via: ☐ Traditional Pathway ☐ Experiential Pathway
- ☐ Recertification
- ☐ Exam Retake, last attempt on: _____

☐ Certified Ostomy Care Nurse (COCN®)
- ☐ Initial Exam
  Applying via: ☐ Traditional Pathway ☐ Experiential Pathway
- ☐ Recertification
- ☐ Exam Retake, last attempt on: _____

☐ Certified Continence Care Nurse (CCCN®)
- ☐ Initial Exam
  Applying via: ☐ Traditional Pathway ☐ Experiential Pathway
- ☐ Recertification
- ☐ Exam Retake, last attempt on: _____

☐ Certified Foot Care Nurse (CFCN®)
- ☐ Initial Exam
  Applying via: ☐ Traditional Pathway ☐ Experiential Pathway
- ☐ Recertification
- ☐ Exam Retake, last attempt on: _____

PROOF OF ELIGIBILITY

Note – all documentation listed will be validated.

Registered Nurse License

☐ RN License Number _____ State: _____ Expiration Date: _____
(attach a copy – online verifications accepted)

Academic Education: (check all that apply)

☐ BSN ☐ Bachelor's Degree in Other Field, list degree:_____
☐ MSN ☐ NP ☐ CNS ☐ Master's in Other Field: _____ ☐ PhD ☐ EdD ☐ DNP
☐ Associate Degree (only applicable to Foot Care) ☐ Other: _____

RECERTIFICATION

Recertification with Current Credentials.

☐ I hold a current/valid WOCNCB Certification (attach a copy – online verifications accepted)

Recertification with Lapsed Credentials. I am applying as (check one):

☐ Traditional Pathway *

☐ Experiential Pathway

Recertification by Exam AND PGP

☐ Recertification in combination of examination and PGP (must complete online application).

LAPSED CREDENTIALS – **EFFECTIVE DECEMBER 2010**

Recertification of lapsed credentials: Please complete the application as you would for an initial certification exam. (If you were a graduate of a WOC Education Program prior to your certification lapse – complete the WOC Education Program Graduate section below; if you were initially certified by Experiential Pathway – complete the WOC Experiential Pathway Applicant section below.)

*Note: beginning December 10, 2010, you will be allowed to recertify lapsed credentials only via examination and must show eligibility to sit for the certification examination via the Experiential Pathway.

TRADITIONAL PATHWAY

☐ WOC (ET) Nursing Education Program CODE: _____ (codes found on page 14 of Handbook)

☐ Foot Care Nursing Education Program CODE:_____(codes found on page 21 of Handbook)

☐ Graduated: _____ (mm/yyyy) (For the foot care specialty exam ONLY, this requirement takes effect on April 1, 2011.)

**NOTE: If your graduation date from WOC(ET)school is older than 5 years, and this will be your INITIAL certification exam, you must apply via the Experiential Pathway (see next section).*

☐ Include a copy of your certificate of completion/graduation.

Authorization of name and score release 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.

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

EXPERIENTIAL PATHWAY – not applicable for those using Traditional Pathway above

Submit the following documentation:

☐ Completed Continuing Education Verification Form with titles and hours (page 27 of this application).

☐ Conference brochure or class syllabus if the educational program covers more than one topic (example: HBO Therapy). A list of examples and sample application are found on the **www.wocncb.org** website.

☐ Copy of the official certificate of completion for CE/CME credits (contact hours).

☐ Completed Experience Verification Form of current/past employment with experience hours (page 28 of this application).

To the best of my ability I state I have attended Continuing Education that supports the core curriculum for self-study as found in the Content Outline for each specialty. The clinical hours (direct patient care) and the continuing education reported on this application have all been completed after I obtained licensure as an RN and/or after completing a bachelor's degree (WOC only).

Signature: _____

PAYMENT

Make check or money order payable to CASTLE or pay by credit card.
If payment is by credit card, complete the following:

☐ Visa ☐ MasterCard

☐ One specialty $300
☐ Two specialties $350
☐ Three specialties $400
☐ Four specialties $450

Card # Exp. Date _____

Your name as appears on card _____

Card number: _____

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 I must keep all documentation that supports my application for submission to the WOCNCB should I be requested to participate in random audits for quality assurance. I understand that applications found to be fraudulent will be reported to my respective Board of Nursing.

Name: _____

Signature: _____ Date: _____

SPECIAL AMERICANS WITH DISABILITIES ACT ACCOMMODATION REQUEST ☐ Yes (See page 10 for details.)

EXPERIENTIAL PATHWAY

CONTINUING EDUCATION VERIFICATION FORM

Name_____ Date_____

1. Complete a form for <u>each</u> specialty area (check one). ☐ Wound ☐ Ostomy ☐ Continence ☐ Foot Care
   (Make copies of form for additional specialties.)
2. Record the number of approved CE/CME credits (contact hours)

List individual educational session/course titles separately. Do not list as "conference" with the total hours. (e.g., "SAWC Conference/24 hours" would need a breakdown listing each session title. For instructions see page 8.)

3. Include copies of each CE/CME certificate.

Program Date(s)	Title of Course	Course Provider	Approved Accrediting Organization	CE or CME Credits (contact hours)
6/2009	Example: Ethics in Wound Care	County General Hospital	Ohio Nurses Association	3
~~6/2007~~	Example of Unacceptable: ~~HBO Course~~	~~Veritas Family Care~~	~~Wisconsin State Board of Nursing~~	48 22.5 hours approved as related to wound care

EXPERIENTIAL PATHWAY

EXPERIENCE VERIFICATION FORM

VERIFICATION OF CURRENT EXPERIENCE (FROM PAST 5 YEARS)

Employment Dates From: ____ /____ /____ To: ____ /____ /____

	Hours worked per year related to direct patient care in the clinical specialty (estimate if needed)	x Number of Years	Total Hours
Wound			
Ostomy			
Continence			
Foot Care			
			Note: Total hours per year reaches maximum at 2,000 hours.

Hospital or Company Name: _____

Address: _____

Supervisor Name: _____

Supervisor Title:_____

Supervisor Phone: _____

VERIFICATION OF PREVIOUS EXPERIENCE – if your hours worked at the current position do not equal the full number of hours required, list the previous employment hours worked from the past 5 years and the contact information here. It is recommended you include a written letter from your supervisor(s) verifying the clinical hours worked.

Employment Dates From: ____ /____ /____ To: ____ /____ /____

	Hours worked per year related to direct patient care in the clinical specialty (estimate if needed)	x Number of Years	Total Hours
Wound			
Ostomy			
Continence			
Foot Care			
			Note: Total hours per year reaches maximum at 2,000 hours.

Hospital or Company Name: _____

Address: _____

Supervisor Name: _____

Supervisor Title:_____

Supervisor Phone: _____

WOUND, OSTOMY OR CONTINENCE EXAMS

I am an immediate supervisor of the WOCNCB exam applicant on this form. I hereby certify that the applicant has completed the number of hours indicated (above) of clinical experience (direct patient care related to the specialty) in wound, ostomy and/or continence. Further, I hereby certify that 375 hours of clinical experience (direct patient care related to the specialty) have occurred within the past ONE year prior to this application date.

Supervisor Signature:_____ Date: _____

FOOT CARE EXAM

I am an immediate supervisor of the WOCNCB exam applicant on this form. I hereby certify that the applicant has completed 8 hours of clinical experience (direct patient care related to the specialty) in foot care. Further, I hereby certify that 8 hours of clinical experience (direct patient care related to the specialty) in foot care occurred within the 5 years prior to this application date.

Supervisor Signature:_____ Date: _____