ACRN
HIV/AIDS NURSING
CERTIFICATION BOARD

Application for Specialty Certification Examination in Advanced HIV/AIDS Nursing Practice

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided. →

A	B	C	D	E	F	1	2	3	4	5	6

Candidate Information

Print your LAST NAME then FIRST NAME then MIDDLE INITIAL

Number and Street

Apartment Number

City

State/Province

Zip/Postal Code

E-mail Address

Daytime Phone

Evening Phone

Current RN License Number

License State

Date of Expiration

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. PERCENT OF WORKING TIME CURRENTLY SPENT IN HIV/AIDS NURSING:
- ○ Less than 25%
- ○ 25 to 50%
- ○ 51 to 75%
- ○ More than 75%

B. PRIMARY POSITION: *(Darken only one response.)*
- ○ Staff Nurse/Clinician
- ○ Head Nurse/Manager
- ○ Case Manager/Coordinator
- ○ Nurse Practitioner
- ○ Clinical Nurse Specialist
- ○ Patient Educator
- ○ Nurse Educator/Faculty Member
- ○ Director/Assistant Director
- ○ Nurse Researcher
- ○ Infection Control Practitioner
- ○ Consultant
- ○ Sales/Marketing Industry Nursing Rep.
- ○ Counselor
- ○ Other

C. AREA OF PROFESSIONAL HIV/AIDS EMPHASIS:
- ○ Adult
- ○ Both adult and pediatrics
- ○ Pediatrics

D. PRIMARY PRACTICE SETTING: *(Darken only one response.)*
- ○ Hospital
- ○ Outpatient/Ambulatory
- ○ Public/Community Health
- ○ Hospice
- ○ Home Care
- ○ School of Nursing
- ○ Private/Group Practice/Physician's Office
- ○ Substance Abuse Treatment Center
- ○ Longterm Care Facility
- ○ Forensic Setting (jail, prison)
- ○ Community-based Organization
- ○ HIV Testing Center
- ○ Primary Prevention Program
- ○ Clinical Trial Group
- ○ Family Planning/STD Clinics
- ○ Other

E. EXPERIENCE IN HIV/AIDS NURSING IN PAST FIVE YEARS:
- ○ 2000 hours
- ○ 2 years
- ○ 3 - 6 years
- ○ 7 - 10 years
- ○ More than 10 years

F. EMPLOYMENT STATUS:
- ○ Full-time
- ○ Part-time
- ○ Unemployed
- ○ Retired

G. PRIMARY PRACTICE LOCATION:
- ○ Rural
- ○ Suburban
- ○ Mixed
- ○ Urban (Less than 1 million population)
- ○ Urban (More than 1 million population)
- ○ Not applicable

H. ARE YOU CURRENTLY CERTIFIED AS AN ACRN?
- ○ No
- ○ Yes

I. OTHER ADVANCED CERTIFICATIONS HELD: *(Darken all that apply.)*
- ○ None
- ○ AOCN
- ○ CIC
- ○ CCNS
- ○ CEN
- ○ Hospice
- ○ BC
- ○ Other

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Application for Specialty Certification Examination in Advanced HIV/AIDS Nursing Practice

Eligibility and Background Information

J. HIGHEST ACADEMIC LEVEL:

- ○ Master of Science with concentration in nursing (MS)
- ○ Master of Science in Nursing (MSN)
- ○ Master of Nursing (MN)
- ○ Master of Arts in Nursing (MA)
- ○ Master of Public Health in community/public health nursing (MPH)
- ○ Doctor of Nursing Science (DNSC or DSN)
- ○ Doctor of Philosophy in nursing (PhD)
- ○ Nursing Doctor (ND)
- ○ Other

K. WHERE DID YOU HEAR ABOUT THE SPECIALTY CERTIFICATION IN ADVANCED HIV/AIDS NURSING PROGRAM? *(Darken all that apply.)*

- ○ ANACdotes
- ○ ANAC Annual Conference
- ○ ANAC Mailing
- ○ Local Chapter Meeting
- ○ Colleagues
- ○ Other journals
- ○ JANAC
- ○ Other

L. ARE YOU CURRENTLY A MEMBER OF ANAC?

○ No ○ Yes *If yes, indicate Membership No.* _____

M. DO YOU/WILL YOU RECEIVE A MONETARY REWARD FOR CERTIFICATION

○ No ○ Yes

N. IS CERTIFICATION PART OF THE JOB PERFORMANCE/CLINICAL LADDER RATING CRITERIA?

○ No ○ Yes

O. ARE YOU CURRENTLY OR HAVE YOU BEEN CERTIFIED IN ADVANCED HIV/AIDS NURSING?

- ○ No
- ○ Yes, currently certified.
  Month/year certification expires: _____/_____
- ○ Yes, certification lapsed.
  Month/year certification lapsed: _____/_____

P. HAVE YOU TAKEN THIS EXAMINATION BEFORE?

○ No ○ Yes

If yes, when and under what name?
Date: _____ *Name:* _____

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your certification.

Race:

○ African American ○ Hispanic ○ Pacific Islander ○ Other
○ Asian ○ Native American ○ White

Age Range:

○ Under 25 ○ 30 to 39 ○ 50 to 59
○ 25 to 29 ○ 40 to 49 ○ 60+

Gender:

○ Male ○ Female
○ Transgender

Experience Validation

To be completed by candidate's nursing supervisor or professional colleague.

By my signature below, I verify that the above-named candidate for the Specialty Certification Examination in Advanced HIV/AIDS Nursing Practice has a minimum of 2,000 hours of HIV/AIDS nursing experience within the five years prior to application.

Signature | Relationship to Candidate | Phone Number

Candidate Signature

I have read the Handbook for Candidates and understand I am responsible for knowing its contents. I certify that the information given in this Application is in accordance with Handbook instructions and is accurate, correct, and complete.

CANDIDATE SIGNATURE: _____ ***DATE:*** _____

CREDIT CARD PAYMENT

If you want to charge your fee on your credit card, provide all of the following information.

Name (as it appears on your card): _____

Address (as it appears on your statement): _____

Charge my credit card for the total fee of: _____

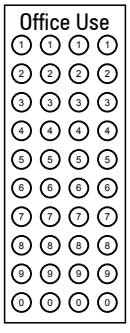
Card type: ___ Visa ___ MasterCard ___ American Express

Expiration date (month/year): |___|___|/|___|___|

Card Number: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Signature: _____

Office Use



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