AACRN
HIV/AIDS NURSING CERTIFICATION BOARD

Application for Advanced Certification Examination in HIV/AIDS Nursing

Candidate Information. Please print clearly.

First Name_____ Middle Initial _____

Last Name_____ Suffix _____

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:

○ Staff Nurse/Clinician ○ Head Nurse/Manager ○ Nurse Practitioner
○ Clinical Nurse Specialist ○ Patient Educator ○ Nurse Educator/Faculty Member
○ Director/Assistant Director ○ Nurse Researcher ○ Infection Control Practitioner
○ Consultant ○ Sales/Marketing Industry Nursing Representative
○ Counselor ○ Other

C. Area of Professional HIV/AIDS Emphasis:

○ Adult ○ Pediatrics ○ Both Adult and Pediatrics

D. Primary Practice Setting:

○ Inpatient: Community Hospital ○ Inpatient: University Affiliated Hospital
○ Inpatient: Teaching Hospital ○ Inpatient: Non-teaching Hospital
○ Outpatient/Ambulatory ○ Public/Community Health
○ Hospice ○ Home Care
○ School of Nursing ○ Private/Group Practice/Physician's Office
○ Substance Abuse Treatment Center ○ Long-term Care Facility
○ Forensic Setting (jail, prison) ○ Community-Based Organization
○ HIV Testing Center ○ Primary Prevention Program
○ Clinical Trial Group ○ Family Planning/STD ○ Other _____

E. Experience in HIV/AIDS Nursing:

○ 2000 Hours ○ Less than 2 years ○ 2 years ○ 3-6 years ○ 7-10 years ○ 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:

○ Master of Science with Nursing concentration (MS) ○ Master of Science in Nursing (MSN) ○ Master of Nursing (MN)
○ Master of Arts in Nursing (MA) ○ Master of Public Health (MPH) ○ Nursing Doctor (ND)
○ Doctor of Nursing Science (DSNC or SDN) ○ Doctor of Philosophy in Nursing (PhD) ○ Other _____

I. Where Did You Hear About the Certification in HIV/AIDS Nursing Program? (Choose all that apply)

○ ANAC Mailing ○ ANAC Chapter ○ Colleagues ○ ANAC Annual Conference
○ JANAC ○ Other Journal ○ Other _____

J. Are you currently a member of ANAC? ○ No ○ Yes *If yes, indicate Membership Number* _____

K. Do you/will you receive a monetary reward for certification? ○ No ○ Yes

L. Is certification part of the job/performance/clinical ladder rating criteria? ○ No ○ Yes

M. Are you currently or have you ever been certified in Advanced HIV/AIDS Nursing?

○ No ○ Yes *If yes, please supply expiration date* _____/_____

N. Have you taken this exam before? ○ No ○ Yes Date_____/_____ Name _____

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

Experience Validation

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.

Name: _____ **Relationship to Candidate:** _____
Signature: _____ _____ **Phone Number:** (____) _____-_____

Candidate Signature

I have read and understand the requirements for candidate eligibility and the cancellation, rescheduling and no show policies. 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:** $_____
Signature: _____ **Date:** _____