ACRN
HIV/AIDS NURSING
CERTIFICATION BOARD

Application for 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:

○ Less than 2 years ○ 2 years ○ 3-6 years ○ 7-10 years ○ More than 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:

○ Diploma in Nursing ○ Diploma/Certificate, Other ○ Associate Degree, Nursing
○ Baccalaureate, Nursing ○ Baccalaureate, Other ○ Associate Degree, Other
○ Masters in Nursing ○ Masters Degree, Other ○ Doctorate in Nursing
○ Doctorate, Other ○ Other _____

I. Other Certifications Held: (Choose all that apply)

○ None ○ R.N.,C ○ OCN ○ CIC ○ CCRN
○ CEN ○ CRNH ○ RN, CS ○ Other _____

J. 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 _____

K. Are you currently a member of ANAC?

○ No ○ Yes *If yes, please indicate Membership Number* _____

L. Are you currently or have you been certified in HIV/AIDS Nursing?

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

M. Have you taken this exam before?

○ No ○ Yes Date_____/_____ Name _____

N. Did you take the online Practice Exam prior to taking the Certification Examination?

○ No ○ Yes

O. Did you take any organized review courses prior to taking the Certification Examination?

○ No ○ Yes Date_____/_____ Location _____

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

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:** _____

This form is for fax or US mail only. For security purposes please do not scan or email this form. Contact HANCB at +1(800) 260-6780.