



# Recertification Clinical Practice Documentation and Affirmation

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Last Name

First Name

Middle Initial

## ***Affirmation***

Affirmation: By signing and submitting this Recertification Application, I accept the conditions stated in the Infusion Nurses Certification Corporation's CRNI® *Recertification Handbook* concerning the certification and/or recertification processes and policies. I certify that the information in this application is true, complete, and correct to the best of my knowledge and is made in good faith. I understand that if any information is later determined to be false, INCC reserves the right to revoke any certification granted on the basis of that false information. INCC reserves the right to publicize certification information and may provide additional information in response to inquiries from state boards of nursing or other such entities.

I further affirm that my nursing license is current, active, and unrestricted.

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Candidate Signature

Date

## **Clinical Practice Statement**

### ***Recertification candidates only***

My signature below serves to document that as a recertification candidate, I have at least 1,000 hours of clinical experience\* in infusion therapy, earned as an RN within the three-year recertification period.

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Recertification candidate's signature

Date

\*Clinical experience can include assessing, planning, implementing, and evaluating the care and needs of patients and clients who require infusion therapy in the course of their care. 1,000 hours of direct clinical bedside experience is not a prerequisite; registered nurses functioning as educators, administrators, or researchers in the infusion nursing specialty are also eligible.

All candidates must provide a supervisor's contact information below. INCC reserves the right to contact your supervisor to verify compliance with our clinical practice eligibility requirements.

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Supervisor's Name

Title

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Company

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Email

Telephone

Name: \_\_\_\_\_

1. Will your employer provide any financial support or reimbursement for maintaining or renewing your credential?

Yes  No

If applicable, do you authorize INCC to contact your employer to thank them for their support?

Yes  No

**If applicable**, please provide name and address of the administrator.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Email

*INCC does not discriminate among candidates on the basis of age, gender, race, religion, national origin, disability, sexual orientation, or marital status.*