CRNI® Examination Application Form

☐ March 2019

Apply online or mail to:
INCC
One Edgewater Drive
Suite 209
Norwood, MA 02062
Fax: (781) 440-9409

Use your legal name. Name must match photo ID used for exam entry and will be printed on your certificate.

Last Name _____ First Name _____ Middle Initial _____

INS Membership # _____ Exp. Date _____

PREFERRED ADDRESS ☐ Home ☐ Business

Title _____ Company (if preferred address is business) _____

Address _____ City _____ State _____ Zip Code _____

(International Only) Province _____ Country _____ Postal Code _____

Phone Number ☐ Home ☐ Business ☐ Cell E-mail Address _____

RN license # _____ State _____ Exp. Date _____

(International applicants must attach documentation of license to practice nursing in country of residency.)

Application Deadlines		
Applications received after regular deadlines are not guaranteed acceptance and will incur a $50 late fee.	Early Bird includes $50 discount	Regular
March 2019 Exam	November 10, 2018	January 10, 2019
Initial Certification Exam Fees		
INS Member	☐ $310	☐ $360
Re/Joining INS*	☐ $420	☐ $470
Nonmember	☐ $450	☐ $500
International Candidates		
International Site Fee	☐ $140	☐ $140

* Includes 1-year INS membership. INS membership fees are nonrefundable.

† Accepted for September exam ONLY. See p. 20 for details.

Registration Fee $ _____
(from selection in box)

☐ Check if you are retaking the exam $ _____
(Subtract $50 from appropriate registration fee if eligible – not valid for recertification)

☐ Check if you are taking the exam outside the United States
(International site fee $140)
$ _____

DISCOUNTS CANNOT BE COMBINED

TOTAL fee enclosed _____

METHOD OF PAYMENT

☐ Check/money order (payable to INCC)

☐ MasterCard ☐ VISA ☐ AMEX

Card # _____

Exp. Date _____

Signature _____

_____
Print cardholder's name

Clinical Practice Documentation and Affirmation Form

Last Name | First Name | Middle Initial

Affirmation

By signing this Affirmation Form, I accept the conditions stated in the Infusion Nurses Certification Corporation CRNI® *Exam Handbook* concerning the administration of the exam, the reporting of scores, the release of information to INS, and the certification and 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 understand that the proctors at any assigned test center are authorized by me to take all actions they deem necessary and proper to administer the test securely, fairly, and efficiently. I acknowledge that the proctors may relocate me before or during the exam.

I further affirm that my RN license is current, active, and unrestricted, OR that I am taking an international exam and hold a current, active, unrestricted license in the country in which I am practicing. I will provide documentation of that license with my exam application.

Candidate Signature | Date

Clinical Practice Statement

New certification candidates only

My signature below serves to document that as a new certification candidate, I have at least 1,600 hours of clinical experience* in infusion therapy. Those 1,600 hours were earned as an RN within the two years before the date of this application.

New certification candidate's signature | Date

Recertification candidates only

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

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. 1,600 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.

Supervisor Information

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.

Supervisor's Name | Title

Company

E-mail | Telephone

Biographical Information

1. Who is paying for your CRNI® exam application?
   - ☐ I am paying for myself.
   - ☐ My employer is paying.
   - ☐ My employer will provide reimbursement on passing.

2. If an employer is providing any financial support or reimbursement for the CRNI® certification and you authorize INCC to contact your employer to thank them for their support, please provide the name and address of the administrator below.

   _____
   Name

   _____
   Title

   _____
   Company Name

   _____
   Address

   _____
   City State Zip

   _____
   E-mail

3. How did you hear about the CRNI® exam?
   - ☐ A peer recommended it.
   - ☐ A supervisor recommended it.
   - ☐ My employer requires specialty certification.
   - ☐ I received a mailing promoting the CRNI®.
   - ☐ I received an e-mail promoting the CRNI®.
   - ☐ I was previously certified.
   - Other _____

4. What do you plan to use to study for the CRNI® exam?
   - ☐ The CRNI® Academy
   - ☐ The *CRNI® Study Guide and Practice Questions*
   - ☐ The *Core Curriculum for Infusion Nursing*, 4th edition
   - ☐ The *Infusion Therapy Standards of Practice*
   - ☐ *Infusion Nursing: An Evidence-Based Approach*
   - ☐ *Policies and Procedures for Infusion Therapy*, 5th edition
   - ☐ *Policies and Procedures for Infusion Therapy of the Older Adult*, 3rd edition
   - ☐ *Policies and Procedures for Infusion Therapy of the Pediatric Patient*, 2nd edition

Special Accommodation Request Form (if applicable)

Special Accommodations for Candidates with Disabilities
In compliance with the Americans with Disabilities Act of 1990, all reasonable special requests will be accommodated. Complete this Special Accommodation Request Form and submit it to INCC with your application and fee, and a letter stating your requirements from a health-care or education professional. *Applications for special accommodations must be received by regular deadlines*.

Scheduling Your Exam
Candidates requesting a special accommodation must schedule their exam by calling PSI/AMP at (888) 519-9901.

Candidate Name _____ _____ _____
(Last) (First) (MI)

Test Site Location _____

Please describe briefly the special accommodation(s) you will need. _____

_____

_____

_____

_____

_____
(Signature)