

EXAMINATION APPLICATION

INITIAL CERTIFICATION AND LAPSED CERTIFICANTS

PRINT NAME		
Last:	First:	MI:
Designation(s):		Current Title:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: Mo: ____ Day: ____ Yr: ____		
HOME MAILING ADDRESS		
Street/P.O. Box:		City:
State/Province:	Country:	Zip/Postal Code:
Daytime Telephone No.:	Evening Telephone No.:	Fax No.:
()	()	()
BUSINESS ADDRESS		
Organization Name:		
Street/P.O. Box:		City:
State/Province:	Country:	Zip/Postal Code:
Business Telephone No.:	Business Fax No.:	E-mail: (required)
()	()	
Preferred Address: <input type="checkbox"/> Home <input type="checkbox"/> Business		Have you previously taken the CBIC examination? <input type="checkbox"/> Yes, and passed <input type="checkbox"/> Yes, and did not pass <input type="checkbox"/> No If yes, on what date was the examination last taken: _____
Certification for which the candidate is eligible: <input type="checkbox"/> initial certification <input type="checkbox"/> lapsed certification		
<p>In order to qualify to sit for your initial (first time) certification, or if your certification has lapsed and you wish to renew your certification, you must apply to take the computer based test (CBT). In order to be eligible to take the CBT, you must meet ALL of the following requirements:</p> <p><input type="checkbox"/> You are a licensed or certified healthcare professional (including, but not limited to, registered nurse, licensed / registered practical nurse [LPN, RPN], nurse practitioner, physician, medical technologist, respiratory therapist) with current registration in good standing with the appropriate licensing board / certification / governing body (e.g. state/provincial medical licensure; state/provincial nursing association or board, etc.), OR have a minimum of a baccalaureate degree;</p> <p>AND</p> <p><input type="checkbox"/> You are currently working in healthcare;</p> <p>AND</p> <p><input type="checkbox"/> Infection prevention and control is one of your primary roles / responsibilities in your current position;</p> <p>AND</p> <p><input type="checkbox"/> You have had sufficient experience in infection prevention and control, which must include active roles in:</p> <ol style="list-style-type: none"> a. Collection, analysis and interpretation of infection prevention outcome data; AND b. Investigation and surveillance of suspected outbreaks of infection; AND c. At least 3 of the following additional activities: <ul style="list-style-type: none"> • Planning, implementation and evaluation of infection prevention and control measures; • Education of individuals about infection prevention and control; • Development and revision of infection prevention and control policies and procedures; 		
<ul style="list-style-type: none"> • Management of infection prevention and control activities; • Consultation on infection prevention and control risk assessment, and prevention and control strategies. <p>There is no specific time requirement for that defines “sufficient experience.” We emphasize that this certification examination is geared towards the infection preventionist who has had at least two years full-time experience in infection prevention and control.</p> <p>You must include ALL of the following with your completed and signed application form:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Proof of current licensure or certification (hard copy of current standing or submission of a webpage or URL for source verification). For those with baccalaureate degrees, a copy of your diploma /degree is required. <input type="checkbox"/> Completed verification statement form (found online under the Candidate Handbook tab) which must be signed by the applicant’s supervisor / director, attesting that the applicant meets all of the requirements above. <input type="checkbox"/> For self-employed applicants only: Please provide names of three references (clients) and three client attestation statements for whom you have provided infection prevention and control consultation in the past 2 years. Clients should be asked by the candidate to complete an attestation form (found online under the Candidate Handbook tab) and to forward the completed form directly to the CBIC Office (not to the applicant). <input type="checkbox"/> Payment of the required fees for the examination. <p>Application forms will be rejected for any candidate who does not provide the required documentation and fees. Payment will not be processed for those who do not meet the criteria.</p>		

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Education level (choose highest level):

- Associate's Degree in Nursing
- Bachelor's Degree in Nursing
- Bachelor's degree (other/non-Nursing)
- Master's degree in:
 - Nursing
 - Microbiology
 - Medical Technology
- Doctorate in Nursing
- Doctorate in Medicine

Specialty: _____

Other (specify) _____

PROFESSIONAL LICENSE OR REGISTRATION/CERTIFICATION:

(choose up to two)

- LPN or RPN Year obtained: _____
- Medical Technologist Year obtained: _____
- Physician Year obtained: _____
- Registered Nurse Year obtained: _____
- Respiratory Therapist Year obtained: _____
- Other (specify) Year obtained: _____
- _____
- None

Year Started in Infection Prevention and Control: _____

PRACTICE SETTING:

(Please choose at least one of the following:)

- Ambulatory Care Veteran Affairs
- Acute Care/Hospital Self-Employed/Consultant
- Behavioral Health Other: _____
- EMS/Public Health
- Home Care
- Long-Term Care

SPECIAL CONSIDERATIONS

Because of functional limitations imposed by a disability, special arrangements will be necessary for the candidate to complete the certification examination.

- Yes No

If yes, please complete and submit the "Request for Special Accommodations" and "Documentation of Disability" forms located online with your exam application and fees at least 45 calendar days prior to the desired examination date. Please inform AMP of the need for special accommodations when scheduling an examination time.

Please return this application and appropriate documents and fees to:

Examination Services
CBIC
555 E. Wells St. Suite 1100
Milwaukee, WI 53202
F: 414/276.3349

Assessment Center Location:

- United States Assessment Center
- International Assessment Center

Please indicate examination and fee:

- First-Time Certifiers
(first-time certifiers or lapsed certifiers) \$310
- First-Time Reapplicant
(valid one time if reapplicant reapplies within 90 days of their first attempt)
. \$260
- International Assessment Center
(include an additional) \$35

If payment is made by check or money order, submit it with this application. Make CHECK or MONEY ORDER payable in U.S. dollars drawn from a U.S. bank to "CBIC".

If payment is made by credit card, provide the following:

- Visa MasterCard American Express Discover

I agree to pay above amount according to card issuer agreement.**

Credit Card No.: _____

Exp. Date: _____

Signature: _____

* A charge of \$20 will apply to checks returned for insufficient funds.

** If rebilling of a credit card charge is necessary, a \$25 processing fee will be charged.

AGREEMENT OF AUTHORIZATION & CONFIDENTIALITY

I have read the eligibility requirements and attest that I meet these requirements.

I understand that I could be audited to verify my eligibility. I understand my certification can be delayed until eligibility is verified.

I authorize the Certification Board of Infection Control and Epidemiology, Inc. to make whatever inquiries and investigations that it deems necessary to verify my credentials and professional standing. I allow the Certification Board of Infection Control and Epidemiology, Inc. to use information from my application and subsequent examination for the purpose of statistical analysis, provided my personal identification with that information has been deleted. I have read and understand the information provided in the Candidate Handbook. I declare that the foregoing statements are true. I understand that false information may be cause for denial or loss of the credential. I understand that I can be disqualified from taking or completing the examination, or from receiving examination scores, if the Certification Board of Infection Control and Epidemiology, Inc. determines that I was engaged in collaborative, disruptive or other prohibited behavior during the administration of the examination.

I further agree to abide by the policies and procedures as set forth in the Candidate Handbook.

Candidate's Signature: _____

Date: _____