CBIC
Certification Board of Infection Control and Epidemiology, Inc.

CIC® EXAMINATION APPLICATION
INITIAL CERTIFICATION AND LAPSED CERTIFICANTS

PRINT NAME (required) Must match ID/drivers license/passport

Last: _____ First: _____ MI: _____

Designation(s): (required)_____ Title: (required) _____

Certification # *(if known)*: _____

PREFERRED MAILING ADDRESS (required)

Street/P.O. Box: _____ City: _____

State/Province: _____ Country: _____ Zip/Postal Code:_____

Daytime Tel. No.: _____ Evening Tel. No.: _____

Email: (required)_____

EXAMINATION DOCUMENTATION:

You must include ALL of the following with your completed and signed application form: (required)

☐ Proof of diploma /degree (Transcript or copy of diploma).

☐ Completed attestation statement form (found online under Exam Applications and Forms) which must be signed by the applicant's supervisor / director, attesting that the applicant meets all of the requirements above.

☐ CV/Resume.

☐ Official job description (Must be provided on employers letterhead w/ signature from Management/HR Dept).

☐ **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 Exam Applications and Forms) and to forward the completed form directly to the CBIC Office (not to the applicant).

☐ Payment of the required fees for the examination.

Application forms will be rejected for any candidate who does not provide the required documentation and fees.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Post-secondary education in healthcare related field *(choose highest level)*: (required)

☐ Associate ☐ Bachelor ☐ Master ☐ Doctorate

(Area of Study): _____

PROFESSION (required)

☐ Infection Prevention & Control Professional
☐ Epidemiologist
☐ Director
☐ Microbiologist
☐ Other: _____

PROFESSIONAL LICENSE OR REGISTRATION/CERTIFICATION: *(choose up to two)* (required)

☐ 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	☐ Acute Care/Hospital
☐ Behavioral Health	☐ EMS/Public Health
☐ Home Care	☐ Long-Term Care
☐ Veteran Affairs	☐ Self-Employed/Consultant

☐ Other: _____

PROFESSIONAL ORGANIZATIONS

If you're not a member of APIC or IPAC Canada and would like more information, please check this box: ☐

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 CBIC of the need for special accommodations when scheduling an examination time.

NOTIFICATION OF SUPERVISOR If you pass the CIC® exam, who would you like us to contact? (e.g., supervisor, director, CNO, etc.)

If you do not want CBIC to notify anyone, please check here ☐

Last: _____ First: _____ MI: _____

Designation(s): _____ Title: _____

Email Address: _____

EXAMINATION PAYMENT

☐ United States Assessment Center: $375 ☐ International Assessment Center: $375

Method of Payment: ☐ CHECK or MONEY ORDER payable in U.S. dollars drawn from a U.S. bank to "CBIC"*
☐ VISA** ☐ MasterCard** ☐ American Express** ☐ Discover**

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. **May take 7-14 Business days to process application.*

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: _____

Please return this application and appropriate documents and fees to:
Examination Services, CBIC; 555 E. Wells St. Suite 1100; Milwaukee, WI 53202. Fax: 414/276.3349