



555 East Wells Street
Suite 1100
Milwaukee, WI 53202
Phone: 414.918.9796
Fax: 414.276.3349
E-mail: info@cbic.org
Website: www.cbic.org

Self-Employed Application Guide

To apply for the Initial CIC examination as a self-employed candidate you will need to submit a paper application to include the items listed below. Please be sure to send the Self-Employed Attestation Statements to your clients to complete, in which they will send back to our office via mail or fax.

You may submit your application prior to CBIC receiving the Self-Employed Attestation Statements. Once CBIC receives the document(s) from your clients, we will process your application. Please note that the application process may take up to 7-10 business days to review.

- Proof of degree (unofficial/official copy of transcript or diploma)
- Resume
- Initial Application
- Self-Employed Attestation Statement (three of your clients must submit this document back to CBIC)

Should you have any questions, please feel free to contact CBIC at info@cbic.org or 414.918.9796.

EXAMINATION APPLICATION

INITIAL CERTIFICATION AND LAPSED CERTIFICANTS

PRINT NAME (required)		
Last (Family):	First:	MI: (if applicable)
Designation(s): (required)		Current Title: (required)
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: Mo: ____ Day: ____ Yr: ____		
HOME MAILING ADDRESS <input type="checkbox"/> (required) preferred		
Street/P.O. Box: (required)		City: (required)
State/Province: (required)	Country: (required)	Zip/Postal Code: (required)
Daytime Telephone No.: (required) ()	Evening Telephone No.: ()	Fax No.: ()
BUSINESS ADDRESS <input type="checkbox"/> (required) preferred		
Organization Name: (required)		
Street/P.O. Box: (required)		City: (required)
State/Province: (required)	Country: (required)	Zip/Postal Code: (required)
Business Telephone No.: (required) ()	Business Fax No.: ()	E-mail: (required)
ELIGIBILITY REQUIREMENTS FOR INITIAL CERTIFICATION		
<p>In order to qualify to sit for your initial certification, you must apply to take the initial certification examination. In order to be eligible to take the initial certification exam, you must meet ALL of the following requirements:</p> <p>You are accountable for the infection prevention and control activities/program in your setting and this is reflected in your current job description.</p> <p>AND</p> <p>You have a post-secondary degree from an accredited academic institution.</p> <p>You must have an Associate's degree or higher from an accredited academic institution. After December 31, 2020 Diploma RN's will not be eligible to sit for the CIC examination**.</p> <p>** After considering appeals and requests from potential CIC® candidates, The Board of Directors of the Certification Board of Infection Control & Epidemiology, Inc. (CBIC) has approved changing the eligibility criteria for individuals who hold a three-year Diploma RN degree. Previously, graduates with Registered Nursing Diploma degrees ("Diploma RNs") were an exclusion and unable to certify. This change will deem Diploma Nurses from accredited institutions eligible to apply for the CIC® certification, effectively immediately and will expire on December 31, 2020. After 2020, "Diploma RNs" will not be eligible to sit for the CIC® exam.</p> <p>AND</p> <p>You have had sufficient experience (recommended: two years) in infection prevention and control which includes all three (3) of the following:</p> <p>*Bullet points are not all inclusive to a candidates role in infection prevention and control*</p>		
<ol style="list-style-type: none"> 1. Identification of infectious disease processes <ul style="list-style-type: none"> • Determining the contributing factor(s) of an outbreak within a facility • Identifying an outbreak within a facility • Coordinating processes, procedures and/or policies to combat identified infectious diseases 	<ol style="list-style-type: none"> 2. Surveillance and epidemiologic investigation <ul style="list-style-type: none"> • Collect, analyze, monitors and communicates infection control data • Monitors and measures the extent of infectious diseases • Detect infectious organisms and their patterns • Partnering with appropriate healthcare team to analyze and perform job 3. Preventing and controlling the transmission of infectious agents <ul style="list-style-type: none"> • Communicating infection data to staff and patients • Coordinating and/or facilitating educational programming for infection control and prevention • Implementation of evidence-based processes specific to preventing and controlling infections <p>And at least two (2) of the remaining five (5) components:</p> <ol style="list-style-type: none"> 1. Employee / occupational health <ul style="list-style-type: none"> • Employed in occupational health/consulting setting 2. Management and communication <ul style="list-style-type: none"> • Manage the infection control and prevention program/processes • Supervise the infection control and prevention program/processes 3. Education and research <ul style="list-style-type: none"> • Educate patients and/or staff about infection control and prevention circumstances • Develop educational programming in infection control and prevention 4. Environment of care <ul style="list-style-type: none"> • Infection Control serves as consultant in construction and renovation, environmental services, emergency management; and more 5. Cleaning, sterilization, disinfection, and asepsis <p>*Equivalent to Canadian two- or three- year diploma from an accredited academic facility</p>	
How would you like to receive your certificate? <input type="checkbox"/> Paper Copy <input type="checkbox"/> Emailed PDF <input type="checkbox"/> Both		<p>Starting February 15th, 2019 all candidates for certification or recertification with CBIC from outside the United States and Canada will only receive digital certificates. If a physical certificate is requested, there will be a \$70 flat fee assessed to cover shipping and handling services.</p> <p>One can request a physical certificate here https://cbic.execinc.com/edibo/CertificateReplacement.</p>

<p>You must include ALL of the following with your completed and signed application form: (required)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Proof of diploma /degree (Transcript or copy of diploma). <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"/> CV/Resume. <input type="checkbox"/> Official job description (Must be provided on employers letterhead w/ signature from Management/HR Dept). <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.</p>	<p>PROFESSIONAL LICENSE OR REGISTRATION/CERTIFICATION: (choose up to two) (required)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;"><input type="checkbox"/> LPN or RPN</td> <td>Year obtained: _____</td> </tr> <tr> <td><input type="checkbox"/> Medical Technologist</td> <td>Year obtained: _____</td> </tr> <tr> <td><input type="checkbox"/> Physician</td> <td>Year obtained: _____</td> </tr> <tr> <td><input type="checkbox"/> Registered Nurse</td> <td>Year obtained: _____</td> </tr> <tr> <td><input type="checkbox"/> Respiratory Therapist</td> <td>Year obtained: _____</td> </tr> <tr> <td><input type="checkbox"/> Other (specify) _____</td> <td>Year obtained: _____</td> </tr> </table> <p><input type="checkbox"/> None</p> <p>Year Started in Infection Prevention and Control: _____</p>	<input type="checkbox"/> LPN or RPN	Year obtained: _____	<input type="checkbox"/> Medical Technologist	Year obtained: _____	<input type="checkbox"/> Physician	Year obtained: _____	<input type="checkbox"/> Registered Nurse	Year obtained: _____	<input type="checkbox"/> Respiratory Therapist	Year obtained: _____	<input type="checkbox"/> Other (specify) _____	Year obtained: _____
<input type="checkbox"/> LPN or RPN	Year obtained: _____												
<input type="checkbox"/> Medical Technologist	Year obtained: _____												
<input type="checkbox"/> Physician	Year obtained: _____												
<input type="checkbox"/> Registered Nurse	Year obtained: _____												
<input type="checkbox"/> Respiratory Therapist	Year obtained: _____												
<input type="checkbox"/> Other (specify) _____	Year obtained: _____												
<p>PLEASE PROVIDE THE FOLLOWING INFORMATION: Education level (choose highest level): (required)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diploma <input type="checkbox"/> Associate <input type="checkbox"/> Bachelor <input type="checkbox"/> Master <input type="checkbox"/> Doctorate <p>Specialty: (required) _____</p>	<p>PRACTICE SETTING: (Please choose at least one of the following:)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Ambulatory Care</td> <td><input type="checkbox"/> Veteran Affairs</td> </tr> <tr> <td><input type="checkbox"/> Acute Care/Hospital</td> <td><input type="checkbox"/> Self-Employed/Consultant</td> </tr> <tr> <td><input type="checkbox"/> Behavioral Health</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> EMS/Public Health</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Home Care</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Long-Term Care</td> <td></td> </tr> </table>	<input type="checkbox"/> Ambulatory Care	<input type="checkbox"/> Veteran Affairs	<input type="checkbox"/> Acute Care/Hospital	<input type="checkbox"/> Self-Employed/Consultant	<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Other: _____	<input type="checkbox"/> EMS/Public Health		<input type="checkbox"/> Home Care		<input type="checkbox"/> Long-Term Care	
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<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Other: _____												
<input type="checkbox"/> EMS/Public Health													
<input type="checkbox"/> Home Care													
<input type="checkbox"/> Long-Term Care													
<p>PROFESSION (required)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infection Prevention & Control Professional <input type="checkbox"/> Epidemiologist <input type="checkbox"/> Director <input type="checkbox"/> Microbiologist <input type="checkbox"/> Other: _____ 	<p>PROFESSIONAL ORGANIZATIONS If you're not a member of APIC or IPAC Canada and would like more information, please check this box: <input type="checkbox"/></p> <p>SPECIAL CONSIDERATIONS Because of functional limitations imposed by a disability, special arrangements will be necessary for the candidate to complete the certification examination. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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.</p>												
<p>NOTIFICATION OF SUPERVISOR: If you pass the CIC® exam, who would you like us to contact? (e.g., supervisor, director, CNO, etc.)</p>													
<p>Last: _____ First: _____ MI: _____</p>													
<p>Designation(s): _____ Current Title: _____</p>													
<p>Organization Name: _____</p>													
<p>Street/P.O. Box: _____ City: _____</p>													
<p>State/Province: _____ Country: _____ Zip/Postal Code: _____</p>													
<p>Daytime Phone No.: _____ Evening Telephone No.: _____ E-mail: (required) _____ () ()</p>													
<p>If you do not want CBIC to notify anyone, please check here <input type="checkbox"/></p>													

ATTESTATION STATEMENT VERIFICATION: Provide information of Management who has signed Document (Required).

Name:
Email:
Phone #:

Please indicate examination location and fee:

United States Assessment Center\$375

International Assessment Center\$375

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.

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

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

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: _____



CLIENT ATTESTATION STATEMENT FOR SELF-EMPLOYED CANDIDATES

In order to be eligible to take the initial certification examination in infection prevention and control (CIC® examination), a self-employed candidate (i.e. independent consultant) must have the following information provided by at least three clients. Candidates should give this form to the client, who then fills it out and submits it to the CBIC Executive Office.

Please complete this form, checking relevant boxes in each section of the form. Return the original signed form to the CBIC Executive Office, who will add it to the candidate's application. If you have questions, please contact the CBIC Executive Office at 414/918.9796.

APPLICANT INFORMATION:

Independent Contractor Consultant

other _____

(List any specific job-titles the applicant is referred to while working within your facility.)

I verify that the following statement is accurate (Check all that are applicable):

The applicant named below is currently providing infection prevention and control services an:

I verify that the applicant's services included all of the indicated elements I have marked below in a satisfactory and acceptable manner:

Identification of infectious disease processes; AND

Surveillance and epidemiologic investigation; AND

Preventing and controlling the transmission of infectious agents; AND

At least 2 of the following additional activities:

Employee/occupational health;

Management and communication;

Education and research;

Environment of care;

Cleaning, sterilization, disinfection, and asepsis;

Consultation on infection prevention and control, risk assessment, and prevention and control strategies;

Other – please explain: _____

Please provide a detailed description of the applicants role in your facility.



CLIENT ATTESTATION STATEMENT FOR SELF-EMPLOYED CANDIDATES

Applicant's Name: _____

Date when Applicant stated working for your facility: _____

Client Name (please print): _____

Client Title: _____

Daytime Phone No.: _____

Client Email: _____

Client Organization: _____

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

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

Client Signature: _____ Date: _____

Please complete this form, checking relevant boxes in each section of the form. Return the original signed form to the CBIC Executive office, who will add it to the candidate's application. If you have questions, please contact the CBIC Executive Office at 414/918.9796.

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