CBIC®
Certification Board of Infection Control and Epidemiology, Inc.

EXAMINATION APPLICATION
INITIAL CERTIFICATION AND LAPSED CERTIFICANTS

PRINT NAME (required)

Last: First: MI: (if applicable)

Designation(s): (required) Current Title: (required)

Gender: ☐ Male ☐ Female Date of Birth: Mo: ____ ____ Day: ____ ____ Yr: ____ ____

HOME MAILING ADDRESS ☐ preferred (required)

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 ☐ preferred (required)

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)

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ELIGIBILITY REQUIREMENTS FOR INITIAL CERTIFICATION

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:

You are accountable for the infection prevention and control activities/ program in your setting and this is reflected in your current job description.

AND

You have a post-secondary degree (e.g. associates'* or baccalaureate degree) from an accredited academic facility.

AND

You have had sufficient experience (recommended: two years) in infection prevention and control which includes all three (3) of the following: *Bullet points are not all inclusive to a candidates role in infection prevention and control*

1. Identification of infectious disease processes
   - 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
2. Surveillance and epidemiologic investigation
   - 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
   - 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

And at least two (2) of the remaining five (5) components:

1. Employee / occupational health
   - Employed in occupational health/consulting setting
2. Management and communication
   - Manage the infection control and prevention program/processes
   - Supervise the infection control and prevention program/processes
3. Education and research
   - Educate patients and/or staff about infection control and prevention circumstances
   - Develop educational programming in infection control and prevention
4. Environment of care
   - Infection Control serves as consultant in construction and renovation, environmental services, emergency management; and more
5. Cleaning, sterilization, disinfection, and asepsis

*Equivalent to Canadian two- or three- year diploma from an accredited academic facility

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

☐ Proof of diploma /degree.

☐ 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.

☐ CV/Resume.

☐ Official job description.

☐ 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).

☐ 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. Payment will not be processed for those who do not meet the criteria.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Education level *(choose highest level)*: (required)

☐ Associate's Degree

☐ Bachelor's Degree

☐ Bachelor's Degree

☐ Master's Degree

☐ Doctorate Degree

Specialty: (required)

_____

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.

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.*

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
F: 414/276.3349

NOTIFICATION OF SUPERVISOR (required)

Last:	First:	MI:
Designation(s):	Current Title:	
Organization Name:		
Street/P.O. Box:		City:
State/Province:	Country:	Zip/Postal Code:
Daytime Phone No.: ( )	Evening Telephone No.: ( )	E-mail: (required)