

## Certification Maintenance Application

Please complete the following application and return to the American Board of Comprehensive Care. Completed application, all supporting materials, and fee must be **received by July 1, 2011**.

CERTIFICATION MAINTENANCE FEE: \$250.00

### General Information

Social security number

Date of Birth  (mm/dd/yyyy)

Gender: Male  Female

Name: First  Middle  Last

Address  Apt.

City  State  Zip

Phone: Daytime  Work

Email

### RN Licensure

State(s) of RN Licensure	License Number	Expiration date of current licensure
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

### APN State Licensure/Registration

State(s) of APN Licensure/Registration	Specialty	License/Registration Number	Expiration date of current License/Registration
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## APN Certification

Organization	Specialty	Certification number	Date certified	Expiration date of current certification
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## DNP Program

Institution

(CCNE or NLNAC accredited school of nursing)

Address

City

State

Zip

Program Director Name

Graduation Date

## Clinical Practice

How many years of clinical practice do you have?

## Diplomate of Comprehensive Care

Date of induction

Date of recertification

Plan for recertification

**Option One – Recertification by Re-examination**

**Option Two – Recertification by Continuing Education and Evidence of Clinical Scholarship**

## Payment

Enclosed is my check or money order payable to: American Board of Comprehensive Care

Charge  
my credit  Visa  Mastercard  
card:

Credit Card No.  Expiration Date  (mm/yyyy)

Print Name on Card  Signature \_\_\_\_\_

## CHECK LIST FOR COMPLETION AND ENCLOSURES:

- Verification of Diplomate conferral
- Verification of current RN licensure
- Verification of APN certification
- Verification of APN state licensure/registration
- Payment enclosed (check signed or credit card number complete)
- Clinical Scholarship record is complete
- All documentation is included
- Application is signed

## Exam Accommodations

I need special exam accommodations and will submit a Test Accommodation Request Form and medical report. Yes  No

(Please see <http://www.abcc.dnpcert.org/examAccommo.shtml> for further information on exam accommodations.)

## Comments/Additional Information



**Mailing Instructions**

Submit an application, copy of RN license, copy of APN certification, copy of DCC certificate, and payment. Remember to attach all required supporting documents. The final deadline is July 1, 2011 for enrollment for certification maintenance. The completed application, supporting material, and fee must be **received by** this date.

US Postal Service:

The American Board of Comprehensive Care  
Box 6  
630 West 168th Street  
New York, NY 10032

FedEX:

The American Board of Comprehensive Care  
617 West 168th Street  
Rm. 252  
New York, NY 10032

For questions & inquiries contact the American Board of Comprehensive Care at **212-305-3254**, email [abcc@dnpcert.org](mailto:abcc@dnpcert.org) or visit the website at [abcc.dnpcert.org](http://abcc.dnpcert.org)

I certify that all the information contained in this application is true and correct. Misstatement of any material fact submitted may be sufficient cause for ABCC to bar me from the examination, to invalidate the results of my examination, to withhold certification, to revoke certification, or to take other appropriate action.

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Signature

Date

**PRINT**

<b>Assessment of clinical scholarship (total of five activities)</b>			
Scholarship	Date of presentation	Title	Sponsor
APRN student lectures			
Journal Article			
Mentoring APRN student		X	X
Oral presentation at professional organization meeting			
Poster presentation at professional organization meeting			