# 2018 CRNFA® Recertification Application Contact Hours

**To recertify your CRNFA credential send application and payment to:**

1. Mail: CCI, 2170 South Parker Road, Suite 120, Denver, CO 80231.
2. Fax: 303-695-8464. Please call 888-257-2667 on the same day to confirm receipt.
3. Email: info@cc-institute.org

## CRNFA Recertification Fees – Recertification by CE

| Early Discount | Standard |
|---|---|
| $450 | $500 |

If you desire to recertify using the Points Method please download that application from the CRNFA section of the CCI website. Applications must be postmarked by July 1, 2018 to receive the early discount.

## Applicant Information

Name: First, Middle, Last

Last 4 digits of SSN | Birth Year

Home Address

City | State | Zip

Work Phone | Home Phone | E-mail

RN – State of Licensure | License Number | Expiration Date

List facilities where you have practiced as an RNFA over the past two years, beginning with your present facility. Do not send resume. Use an additional sheet of paper if more space is needed.

| From Mo/day/yr | To Mo/day/yr | Employer and Address | Position, title, specialty Ex. Staff RNFA | Supervisor's Name | Hours per Week |
|---|---|---|---|---|---|
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## Employment Verification

Please provide contact information for your current nurse administrator.

Current Supervisor's Name _____ Current Supervisor's Email _____

Current Supervisor's Phone _____

Please provide contact information for a surgeon you currently work with, so we may verify your role and performance as a first assistant at surgery.

Surgeon Name _____ Facility _____

Surgeon Phone _____ Surgeon Email _____

**Practice Requirement:** State the total number of hours you have practiced as a CRNFA between January 1, 2013 and December 31, 2017.

Total hours (not years): _____

I attest by signature that I have practiced these hours as a CRNFA, and I am currently employed in perioperative nursing.

Applicant's Signature: _____ Date: _____

**Statement of Understanding.** I hereby apply for recertification offered by the Competency & Credentialing Institute. I understand that recertification depends upon the successful completion of the specified requirements. I further understand that the information acquired in the recertification process may be used for statistical purposes and for evaluation of the recertification program. I further understand that the information from my recertification records shall be held in confidence and shall not be used for any other purposes without my permission. To the best of my knowledge, the information contained in this application is true, complete, correct and made in good faith. I understand that information supplied is subject to audit, and that failure to respond to a request for further information will result in termination of the application process. I understand that CCI reserves the right to verify any or all information on this application. I affirm and attest that I have read and agree to abide by the Statement of Understanding.

Applicant's Signature:_____Date: _____

## Payment Information

☐ Check or Money Order (Make payable to "CCI") ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

_____ _____/_____

Credit Card Number Expiration Month/Year Security Code

_____ _____

Billing Zip code Cardholder Signature

Billing State:_____Amount to be charged to credit card: $_____Date:____/___/_____

## AUDIT DOCUMENTATION

A percentage of recertification applications will be randomly selected for audit. If you are selected, you will be notified after you have submitted your recertification application. Applicants chosen for audit will be required to submit copies of specific documentation, as outlined below.

1. CONTINUING EDUCATION
    a. Copies of certificate(s) of attendance from an acceptable provider for each CH listed.

2. PRACTICE HOURS
    a. Completed employment verification. If selected for audit a template for the employment verification letter will be sent to you.

## CONTACT HOUR REQUIREMENTS

| If you have | You need | The CHs must be |
|---|---|---|
| 1,000 clinical practice hours or more | 200 contact hours | 100 RNFA Related/50 Periop Related |
| Between 500 and 1,000 clinical practice hours | 300 contact hours | 150 RNFA Related/75 Periop Related |

Contact hours must be earned through offerings sponsored by acceptable accredited providers. In addition, each certificate you are awarded for your continuing education activities must have an accreditation statement and/or provider number. A printout of your CE log from CCI website may be used here in lieu of this form. You may print out the contents of the CE log and include with this packet.

## CONTACT HOUR LOG

| Program Title | Date of Program | Name of Provider | Accredited By | Contact Hours |
|---|---|---|---|---|
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| Program Title | Date of Program | Name of Provider | Accredited By | Contact Hours |
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