2018 CRNFA® Recertification Application Exam

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 Testing

Fee
$550

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 #

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

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 this signature that I have read and agree to the *Transfer Policy* found on the CCI website.
- ☐ I attest by this signature that I have read and agree to the *Withdrawal Policy* found on the CCI website.
- ☐ I attest by signature that I have practiced these hours as a RNFA and I am practicing at a minimum on a part time basis in the RNFA role.

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. PRACTICE HOURS
    a. Acceptable proof of practice hours is a log of practice hours or a letter from the surgeon(s) on letterhead verifying that the certificant has met the practice hour requirement.

ADA Accommodation

Whenever possible, CCI is committed to providing reasonable accommodation in its examination processes to otherwise qualified individuals with physical or mental disabilities in accordance with the Americans with Disabilities Act (ADA). Accommodations will be provided to qualified candidates with disabilities to the extent that such accommodation does not fundamentally alter the examination or cause an undue burden to the agency.

CHOOSE ONE OF THE FOLLOWING

❒ I do NOT require ADAaccommodations,

❒ I DO require ADAaccommodations.

Please indicate the type of accommodation below. Should you require a different type of accommodation, please contact CCI prior to mailing your application.

- ❒ Separate room
- ❒ Time and a half