



ANCC proudly offers certification for

Acute Care Nurse Practitioner

eligibility criteria

- > Hold a current, active RN license in a state or territory of the United States or the professional, legally recognized equivalent in another country
- > Hold a master's, post-master's, or doctorate from an acute care nurse practitioner program accredited by the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC). A minimum of 500 faculty supervised clinical hours must be included in your acute care nurse practitioner program. The ACNP graduate program must include course work in:
 - > advanced health assessment
 - > advanced pharmacology
 - > advanced pathophysiology
- > AND, content in
 - > health promotion and disease prevention, and
 - > differential diagnosis and disease management

**All requirements must be completed prior to application for the examination.
An incomplete application affects a candidate's ability to test.**

For more information: www.nursecredentialing.org



Acute Care Nurse Practitioner

Overview of test content outline Effective date: March 1, 2010. If you are testing before March 1, 2010, please view the appropriate test content outline on the ANCC website. For full test content outline, go to www.nursecredentialing.org

Please note that the entire test content outline is associated with health related problems/issues of adult patients (ages 18 years and above) as indicated in Note 1, Note 2 and Note 3.

I. Nurse Practitioner/Patient Relationship

- A. Establish an effective professional therapeutic relationship
 - 1. Knowledge of components of a therapeutic relationship; strategies for establishing therapeutic relationships, considering patient preferences and culture
 - 2. Skills in establishing rapport; planning for patient and family psychosocial and spiritual needs
- B. Maintain an effective professional therapeutic relationship
 - 1. Knowledge of:
 - a. Advance directives
 - b. Privacy and confidentiality
 - c. How crisis situations affect therapeutic relationships
 - 2. Skills in:
 - a. Serving as a patient advocate on issues related to health care management
 - b. Communicating therapeutically
 - c. Promoting patient autonomy
 - d. Collaborating

II. Assessment and Diagnosis

- A. Perform a comprehensive health assessment
 - 1. Knowledge of:
 - a. Appropriate level of history and physical examination
 - b. Anatomy and physiology
 - c. Normal and abnormal assessment findings
 - 2. Skill in:
 - a. Obtaining an appropriate medical history
 - b. Performing an appropriate physical examination
 - c. Performing an appropriate psychosocial assessment
- B. Analyze patient-specific risks
 - 1. Knowledge of:
 - a. Life stages
 - b. Epidemiology

- 2. Skill in:
 - a. Screening tests
 - b. Identifying risk factors
 - c. Performing risk analyses
- C. Develop differential diagnoses
 - 1. Knowledge of:
 - a. Pathophysiology
 - b. Invasive and non-invasive diagnostic tests indications, patient preparation, risk benefit analysis, complications
 - 2. Skill in:
 - a. Obtaining and appraising existing data to determine the need for testing
 - b. Ordering appropriate diagnostic tests
 - c. Diagnostic reasoning
 - d. Developing differential diagnoses
 - e. Prioritizing differential diagnoses
 - f. Confirming the clinical diagnosis

III. Clinical Management

- A. Formulate and implement a patient-specific, cost-effective plan of care
 - 1. Knowledge of:
 - a. Evidence-based practice
 - b. Standards of care and clinical guidelines
 - c. Invasive and noninvasive procedures: indications, patient preparation, risk benefit analysis, complications
 - 2. Skill in:
 - a. Managing complex acute, chronic, and critical conditions
 - b. Prescribing appropriate pharmacologic treatment
 - c. incorporating complementary therapies into the plan of care
 - d. Providing appropriate symptom management
 - e. Prescribing assistive and/or life support devices
 - f. Obtaining appropriate services

- g. Integrating evidence-based care into practice
- h. Formulating interdisciplinary discharge plans
- i. Facilitating appropriate care at the end-of-life
- j. Documenting care provided
- B. Incorporate health promotion and health protection in the plan of care
 - 1. Knowledge of:
 - a. Health promotion activities
 - b. Common risks
 - c. Evidence-based practice related to the management of risk factors
 - d. Disease-related and age-related risk factors
 - 2. Skill in:
 - a. Modifying the patient's plan of care based on identified risk factors
 - b. Promoting follow up
 - c. Incorporating care to prevent exacerbation of coexisting conditions
- C. Provide patient and family education
 - 1. Knowledge of:
 - a. Expected and unexpected complications related to the patient's illness trajectory
 - b. Factors that promote patient adherence and learning
 - c. Self care management strategies
 - d. Considerations related to adult learners
 - 2. Skill in:
 - a. Determining learning needs
 - b. Synthesizing advanced knowledge for the patient
 - c. Ordering consults and additional supports for patient education
 - d. Tailoring content to meet patient and family needs and goals
 - e. Coaching the patient through behavior changes

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- D. Evaluate and modify the plan of care
 - 1. Knowledge of patient-specific disease process; & cost effectiveness
 - 2. Skill in:
 - a. Identifying desired outcomes for the patient
 - b. Evaluating patient responses to teaching
 - c. Identifying and responding to complications
 - d. Using standards of care and guidelines to evaluate outcomes of care
 - e. Using evidence-based practice to evaluate outcomes of care
 - f. Using quality indicators to evaluate outcomes of care
- IV. Health Care Delivery**
- A. Coordinate patient-focused care among health care providers and between health care settings
 - 1. Knowledge of health care policy; available resources; regulatory & accrediting guidelines
 - 2. Skill in:
 - a. Communicating appropriate care-related information to other providers
 - b. Promoting the efficient use of resources to achieve optimal outcomes
- c. Incorporating current & appropriate information technology in the provision of care
 - d. Negotiating to implement the plan of care with the patient, family, & interdisciplinary team
 - e. Navigating the health care system
- B. Evaluate and influence health care policy on the delivery of care
 - 1. Knowledge of federal and state regulations; health care financing; concepts in health care policy
 - 2. Skill in interpreting and evaluating institutional, federal, and state regulations; identifying issues affecting access to care
 - C. Promote quality health care
 - 1. Knowledge of quality improvement processes; safety initiatives
 - 2. Skill in:
 - a. Engaging in continuous quality improvement
 - b. Responding appropriately to identified safety problems
 - c. Managing conflicts
 - d. Communicating effectively across disciplines
 - e. Preventing errors
- V. Professional Responsibility**
- A. Function within the acute care nurse practitioner scope of practice
 - 1. Knowledge of scope and standards of acute care nurse practitioner practice
 - 2. Skill in:
 - a. Credentialing and privileging
 - b. Identifying situations outside the scope of practice
 - c. Managing competing demands appropriately and effectively
 - d. Advocating for the acute care nurse practitioner role
 - e. Collaborating with other health care providers
 - B. Incorporate ethical and legal principles into clinical practice
 - 1. Knowledge of:
 - a. Ethical and legal principles
 - b. Standards of professional behavior
 - c. Principles of risk management
 - d. Medical futility
 - 2. Skill in:
 - a. Obtaining informed consent
 - b. Resolving ethical dilemmas
 - c. Protecting patient autonomy
 - C. Apply evidence into clinical practice
 - 1. Knowledge of components of evidence-based practice; research methods
 - 2. Skill in analyzing, synthesizing, and evaluating evidence; integrating evidence into practice

Notes

Note 1: System-Specific Health Problems

- A. Cardiovascular
- B. Pulmonary
- C. Endocrine
- D. Neurologic
- E. Renal/genitourinary/gynecologic
- F. Gastrointestinal
- G. Hematology/oncology
- H. Immunology
- I. Musculoskeletal

Note 2: Psychosocial Health Issues

- A. Violence
- B. Substance abuse
- C. Sexuality
- D. Powerlessness
- E. Altered mental status/anxiety/grief/depression

Note 3: Common Problems in Acute Care

- A. Fever/infections/wound management
- B. Shock
- C. Nutritional, fluid, electrolyte, & acid-base imbalances
- D. Poisoning & drug toxicities
- E. Immobility
- F. Palliative care
- G. Transplantation
- H. Acute/Chronic pain

Acute Care Nurse Practitioner

2008-2010 Application Fees

 Prices below include \$140 non-refundable administrative fee

ANA Member	\$270	Required attachment: A copy of your American Nurses Association membership card (Full and Direct ANA members only. Individual Affiliate members excluded from this offer.)
Discount	\$340	Required attachment: A copy of your American College of Nurse Practitioners membership card
Non-Member	\$390	

Additional Special Fees:

International Testing	\$125	See www.nursecredentialing.org for details.
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Preparing for the Exam

This exam is a computer-based test. This means you can apply all year and test during a 90-day window at a time and location convenient to you. Applications for this certification will be accepted at any time.

Detailed information about the application and testing process, withdrawing an application, ineligible to test, and other frequently asked questions is in the General Testing and Renewal Handbook available at www.nursecredentialing.org. From this website, you can type into, save, and print your application. Please sign, attach required documents, and mail the complete application. ANCC will review it to determine whether your application meets eligibility criteria.

Information to prepare for the exam, such as review courses, detailed test content outline, references, and sample questions, is available at www.nursecredentialing.org or call our Customer Care Center at 1.800.284.2378.

If you require a verification of exam eligibility and/or certification, visit www.nursecredentialing.org or call 1.800.284.2378.

Mailing Instructions

Print legibly using either black or blue ink. **Keep a photocopy of your application for your records.** Submit an application, copy of RN license (if your board of nursing issues a paper license), and payment. Remember to attach all required supporting documents and mail to:

**American Nurses Credentialing Center
P.O. Box 791333
Baltimore, MD 21279-1333**

DETACH HERE

Complete application
and mail to ANCC.

Acute Care Nurse Practitioner

General Information

1

Use your legal name on the application. This name must match photo identification used for examination entry and will be the name printed on your certificate.

Last Name First Name MI

Maiden or Other Past Legal Names Social Security Number

Home Address

City State Zip/Postal Country

Home Phone Home Fax Personal E-Mail

Employer Name

Employer Address

City State Zip/Postal Country

Work Phone Work Fax Work E-Mail

Type of primary position:

- | | | |
|---|--|--|
| <input type="checkbox"/> Nurse Manager | <input type="checkbox"/> Associate/Assistant Administrator | <input type="checkbox"/> Clinical/Staff Nurse |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Educator | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Administrator/DON/CNO/VP Nursing | <input type="checkbox"/> Researcher | <input type="checkbox"/> Consultant |
| | | <input type="checkbox"/> Other: _____ |

Payment

2

- | | |
|---|---|
| <input type="checkbox"/> Personal Check/Money Order (payable to ANCC) | Amount Enclosed: _____ |
| <input type="checkbox"/> Charge Card (MasterCard or VISA only) | Amount to be charged: _____ |
| <input type="checkbox"/> Check here if this is an ATM/Debit card. See authorization below.* | Promotional Code (if applicable): _____ |

Account Number Exp. Date

Print Name on Card Signature

* ATM/Debit Card users only: I understand and agree that, by using an ATM/Debit card, I am authorizing ANCC to debit my account for the amount specified above. Further, I understand and agree that, if the ATM/Debit transaction fails or is declined, I am authorizing ANCC to complete the transaction as a credit card charge, if possible.

Special Accommodations/Americans with Disabilities Act

3



- Check here if you have a disability as defined by the Americans with Disabilities Act (ADA) and require a special accommodation. Please call 1.800.284.2378 for instructions or visit www.nursecredentialing.org/ADA.aspx

Validation of Nurse Practitioner Education Program

INSTRUCTIONS Allow sufficient time for the **program director to complete and return the original form** to you for inclusion with your application. Only the original document including the original signature and dates is accepted. (A photocopy or faxed document is not accepted). Only forms received within one-year of the program director's signature are accepted.

Applications received with outdated or incomplete forms will delay the review process and impact your ability to take the exam. The current program director completes items 1-10 and returns the original form to the candidate to include with your application. Please type or print all information.

Candidate's Name (Last, First, MI)

Social Security Number

1. The individual named above graduated from:

Name of University/School

School Code (Available at www.nursecredentialing/cert/school_codes.cfm) This allows ANCC to provide an aggregate data report.

Designate the organization(s) which accredit(s) your program:

Commission on Collegiate Nursing Education (CCNE) National League for Nursing Accrediting Commission (NLNAC)

Program Name (e.g. Adult Nurse Practitioner)

Program Address

Program Telephone Number

2. Date candidate completed this graduate program: _____

Did this candidate complete a dual program? No Yes, If yes, then specify the role and specialty completed. Also, provide a detailed description of the content for each role and specialty completed by the candidate.

3. Check the type of program and date degree conferred:

- a. Master's in Nursing conferred on _____
- b. Doctorate in Nursing conferred on _____
- c. Post-Graduate Certificate in nursing completed on _____

Required Attachment: Provide a detailed description of the courses and clinical hours accepted from previous graduate program(s) and list all courses and clinical hours in the post-graduate certificate program that support eligibility.

4. Check the one Nurse Practitioner area of concentration completed:

- | | |
|---|--|
| <input type="checkbox"/> Acute Care Nurse Practitioner | <input type="checkbox"/> Family Psychiatric-Mental Health Nurse Practitioner |
| <input type="checkbox"/> Adult Nurse Practitioner | <input type="checkbox"/> Gerontological Nurse Practitioner |
| <input type="checkbox"/> Adult Psychiatric-Mental Health Nurse Practitioner | <input type="checkbox"/> Pediatric Nurse Practitioner |
| <input type="checkbox"/> Family Nurse Practitioner | |

5. Indicate the separate course number(s) and course title(s) for graduate content for:

Advanced Health Assessment

Advanced Pharmacology

Advanced Pathophysiology

Validation of Nurse Practitioner Education Program

6. Write the course number(s) and title(s) for the following graduate content or write none:

NP Role

NP Practicum Hours

NP Population Focus

Health Promotion and Disease Prevention

Differential diagnosis and disease management

7. Total number of Nurse Practitioner didactic credits: _____

8. TOTAL Faculty supervised clinical hours: _____

A. NP ROLE: Write the exact number of faculty supervised clinical hours completed by this candidate in the **NP role and population** identified in item 6. _____

B. DUAL APRN PROGRAMS: Write the exact number of faculty supervised clinical hours completed by this candidate for the entire program. _____

C. POST-GRADUATE PROGRAM: Write the exact number of faculty supervised clinical hours completed by this candidate for the post-graduate certificate. _____

D. PREVIOUS GRADUATE PROGRAM: Write the exact number of faculty supervised clinical hours accepted from your previous graduate program as described in item 3. _____

9. For Psychiatric-Mental Health nurse practitioner specialty only (The candidate must complete at least 2 modalities) Please check the psychotherapeutic treatment modalities in which the candidate received supervised clinical training at the graduate or post graduate level and indicate the course name and course number:

Psychotherapeutic Treatment Modalities	Course(s) Title and Number
<input type="checkbox"/> Individual	_____
<input type="checkbox"/> Group	_____
<input type="checkbox"/> Family	_____
<input type="checkbox"/> Expressive Therapies	_____
<input type="checkbox"/> Milieu	_____
<input type="checkbox"/> Play Therapy	_____
<input type="checkbox"/> Other	_____

10. Program Director Signature Your signature on this form attests that the above named individual completed the graduate nursing education program as indicated on this document and completed all course work as stated on this form. Completion of this information does not convey approval of a school program or eligibility for a candidate to test. Confirm your school code in item 1 to facilitate ANCC providing your annual aggregate data report.

Program Director (Print Name) _____ Telephone (If different than above) _____

Program Director's Signature _____ Date _____

Education

Check all that apply:

- Diploma
 Associate Degree in Nursing
 Associate Degree in Other Field
 Baccalaureate in Nursing
 Baccalaureate in Other Field
 Master's in Nursing
 Master's in Other Field
 PhD in Nursing
 PhD in Other Field
 EdD
 DNP
 DNSc
 ND
 Other: _____

Check one of the following:

- I have requested my school send transcripts directly to ANCC.
 I have obtained transcripts in a sealed envelope directly from my school and have attached these transcripts to this application.

Please list all degrees you have been awarded with the most recent degree first (do not include high school). Attach additional page if necessary.

Required attachment: All official advanced degree transcripts. The following are not accepted: photocopies, faxes, attached transcripts that are not in a sealed envelope from the school.

School Name	School Code
Major/Area of Study	Date and Degree Conferred
School Name	School Code
Major/Area of Study	Date and Degree Conferred

School codes:

Available on-line at www.nursecredentialing.org/certapp/schoolcodes.cfm

Licensure Information

All candidates must complete this section in its entirety.

Required attachment: Attach a copy of license Check this box if your state does not issue a paper license
 Check this box if your RN license is not from a state or territory of the United States

Current RN License Number _____

State/Country _____

Expiration Date (month/date/year) _____

Statement of Understanding

I hereby apply for certification offered by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for certification. I understand that I am subject to all eligibility requirements for certification as described in this application and that eligibility for certification depends on successfully completing specified certification program requirements. If certified, my name will be included in the official listing of certified nurses.

By signing below, I authorize ANCC staff and the Commission on Certification to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to verify my credentials, education preparation, practice, professional standing, and any other information included in, submitted with, or necessary for review of this application.

I expressly acknowledge and agree that information accumulated by ANCC through the certification process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to schools or external researchers. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without my permission.

I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature, that I will maintain an active registered nurse license throughout the entire certification period, including all renewal periods. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for certification shall be sufficient cause for ANCC to: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; withhold this or other ANCC certifications; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

I further understand that if my certification record is audited, I will be required to submit documentation to support the information in my application. I further understand that if I fail to timely submit supporting documentation, ANCC can: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

(Applications received without a signature incur a delay in processing which will cause a delay in the review of your application and ability to take a certification examination.)

Required Signature _____

Print Name _____

Date _____

MAILING LIST REFUSAL

ANCC may release mailing lists from its certification database to organizations or individuals who have information to distribute that would be beneficial to nurses or to nursing and credentialing research. If you do not wish your name and mailing address to be released for marketing purposes, please mark the decline option below.

- I do not wish my name and mailing address to be released for any marketing purposes.

Demographic and Employment Information

1. Location of facility:
 Urban
 Rural
 Suburban
 Outside the U.S.
2. Average number of patient encounters/visits per year at your primary place of employment:
 ≤1,000
 1,001–5,000
 5,001–10,000
 10,001–20,000
 20,001–40,000
 40,001–60,000
 60,001–80,000
 80,001–100,000
 >100,000
3. Will you receive a monetary reward/compensation from your employer for certification?
 Yes No
 If yes:
 \$ _____ per hour
 \$ _____ per year
 \$ _____ one time
4. Number of individuals you supervise:

5. Years of experience as an RN (round to nearest whole year): _____
6. Total years of experience in the field in which certification is desired (round to nearest whole year): _____
7. Primary place of employment (check one):
 Ambulatory care
 Physician-managed group practice
 Home health
 Hospice
 Hospital
 Managed care
 Nurse-managed group practice
 Nursing home
 Long-term care
 Occupational health/environmental health
 Office nursing
 Public health/community health
 School health
 School of nursing/university/college
 Federal/military
 Other: _____
8. Patient population/conditions representative of your practice (check all that apply):
 Medical-Surgical
 Cardiac
 Endocrine/Diabetes
 Pulmonary
 Neurology
 Renal/Urology
 Orthopedics
 Rehabilitation
 Gerontology
 Long Term Care
 Perinatal
 Post-partum
 Labor & Delivery
 Pediatrics
 ER
 Trauma
 Critical Care
 Other: _____
9. Age range of your primary patient population:
 0–1
 2–21
 22–65
 66+
10. Average number of hours worked per week:
 8 or fewer
 9–16
 17–24
 25–32
 33–40
 >40
11. Size of facility (total number of beds):
 N/A
 1–100
 101–250
 251–500
 >500
12. Is certification part of your employer's job performance/clinical ladder rating criteria?
 Yes No
13. How did you obtain this application?
 From ANCC website
 Mailed from ANCC
 From my school
 From my workplace
 At a tradeshow
 Other: _____
14. Please check the professional organizations in which you are a member (check all that apply):
- | | |
|---|---|
| <input type="checkbox"/> AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation | <input type="checkbox"/> ANA American Nurses Association |
| <input type="checkbox"/> AADE American Association of Diabetes Educators | <input type="checkbox"/> ASPMN American Society for Pain Management Nursing |
| <input type="checkbox"/> AAACN American Academy of Ambulatory Care Nursing | <input type="checkbox"/> GAPNA Gerontological Advanced Practice Nurses Association |
| <input type="checkbox"/> ACNP American College of Nurse Practitioners | <input type="checkbox"/> ISPN International Society of Psychiatric-Mental Health Nurses |
| <input type="checkbox"/> ADA American Diabetes Association | <input type="checkbox"/> NACNS National Association of Clinical Nurse Specialists |
| <input type="checkbox"/> ADA American Dietetic Association | <input type="checkbox"/> NGNA National Gerontological Nursing Association |
| <input type="checkbox"/> ANI Alliance for Nursing Informatics | <input type="checkbox"/> NNSDO National Nursing Staff Development Organization |
| <input type="checkbox"/> APhA American Pharmacists Association | <input type="checkbox"/> PCNA Preventive Cardiovascular Nurses Association |
| <input type="checkbox"/> APNA American Psychiatric Nurses Association | <input type="checkbox"/> SVN Society for Vascular Nursing |
| <input type="checkbox"/> APHA American Public Health Association (Public Health Nursing Section) | <input type="checkbox"/> Other: _____ |

Other Demographic Information

Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Sex: M F

Date of Birth: _____
 month/date/year

Race/Ethnic Group

- | | |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black/African-American | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hispanic | |

To Do List

Date completed:

Read this entire application, front to back.

Determine whether you are/when you will be eligible to take the exam.

Complete any missing requirements such as practice hours or continuing education hours.

Download the full length Test Content Outline and Reference List for this exam at the ANCC website: **www.nursecredentialing.org** These documents are used to create the exam.

Download and read the General Testing and Renewal Handbook from **www.nursecredentialing.org** for a comprehensive listing of policies and critical certification candidate information.

STUDY PLAN

Approximately six months before you plan to take your exam, develop a study plan. This could include self study, finding a study buddy or group, taking a review course, taking an on-line narrated course, reviewing current textbooks and articles, or other methods. The key is to have a study plan and follow through with it. For ANCC exam preparation resources, refer to the back cover of this brochure.

Review the sample test questions on the ANCC website at **www.nursecredentialing.org**

FILL OUT THE APPLICATION

Two to three months before you plan to take the exam, fill out the application, attaching all required documents.

Required attachments: (please mail everything together in one envelope)

Photocopy of RN license (if your board of nursing issues a paper license)

Official transcript(s) in a sealed envelope. Transcripts may be mailed separately by the university directly to the P.O. Box below.

Photocopy of membership card (if you are claiming a discount)

Payment (if you are paying by check)

Attachments for special circumstances:

Those requesting special accommodations under the Americans with Disabilities Act (ADA) must submit a physician's letter that addresses specific required information. Please go to **www.nursecredentialing.org** or call 1.800.284.2378 for full instructions.

MAIL APPLICATION

Mail your application and attachments to:

American Nurses Credentialing Center

P.O. Box 791333

Baltimore, MD 21279-1333

Within two weeks from the date you mailed your application, you will receive a Receipt of Application Notice in the mail. If you do not, call 1.800.284.2378.

Within eight weeks from the date you mailed your application, you will receive either an Eligibility Notice or a letter requesting additional information. Your Eligibility Notice will give you 90 days during which to schedule and take your exam. Read it carefully and follow directions.

RESULTS

After you have taken your exam, you will receive results instantly at the test site. If you passed, you will receive a certificate and pin within two months. Certifications are good for 5 years.

Request your one free verification of certification at **www.nursecredentialing.org** Additional verifications of certification can also be ordered from this site. ANCC does not automatically send verification to your state board of nursing or employer. Please request the verifications you need.

After you pass the exam, download the Certification Renewal materials from the ANCC website at **www.nursecredentialing.org** and begin planning for your certification renewal.

Exam Preparation Resources

Review Seminars

Review Seminars for certification exams are available for fifteen different nursing specialties at various hospitals and schools of nursing across the country. Participants receive contact hours. Seminar schedule and registration at: www.nursecredentialing.org

Study Groups

Using the content from the seminars, the faculty lecture on the material during several telephone conference calls scheduled during a specific time period. Look for the "Study Group" courses in the seminar schedule. Participants receive contact hours. Study Group schedule and registration at: www.nursecredentialing.org

On-Line Narrated Review Courses

Our On-Line Narrated Review Courses contain the same content as our popular Review Seminars, with the voice over of an instructor talking the student through the material. After you register for the course, you will have three months in which to complete the materials. Participants receive contact hours. For more information and to register: www.nursecredentialing.org

Review and Resource Manuals

Written by nursing experts in each specialty, these manuals help candidates prepare for a variety of certification exams by enhancing your critical thinking skills and identifying strengths and weaknesses. Contact hours available on-line for an additional fee. Order manuals at: www.nursecredentialing.org

Certified Nurse Products

Once you have passed your exam, celebrate your accomplishment with pins, plaques, and other recognition items. www.nursecredentialing.org

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), provides individuals and organizations throughout the nursing profession with the resources they need to achieve practice excellence. ANCC's internationally renowned credentialing programs certify nurses in specialty practice areas; recognize healthcare organizations for promoting safe, healthy work environments through the Magnet Recognition Program® and the Pathway to Excellence Program™; and accredit providers of continuing nursing education. In addition, ANCC provides leading-edge information and education services and products to support its core credentialing programs. All programs of the ANCC are administered without discrimination on the basis of age, color, creed, disability, gender, health status, lifestyle, nationality, race, religion, or sexual orientation. ANA is accredited as a provider of continuing nursing education by ANCC's Commission on Accreditation. ANA is approved as a provider by the California Board of Registered Nursing, Provider number 6178.



P.O. Box 791333
Baltimore, MD 21279-1333
1.800.284.2378

www.nursecredentialing.org

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