

# Application for Recertification

**2010-2012**  
Recertification  
Expiration Date: 7/31/2012

**Name:** ..... **AANA ID #:** .....

**Address:** .....

City ..... State ..... Zip + 4 .....

**Email:** .....

**Home Phone:** ..... **Cell Phone:** .....

Check if this is a new name, address, email, or phone.

**You will not be recertified unless this application is returned to the National Board on Certification and Recertification of Nurse Anesthetists with all fees, copy of RN and/or APRN license(s), record of practice and signature.**

**A. Application**

- Complete, sign, and return application and all required materials immediately. Faxes are not accepted.
- Allow 4 weeks for processing.

**B. Recertification Fees**

- The recertification application fee is \$100.00.
- The CE credit processing fee is \$300.00; required in addition to the application fee for applicants who do not have either AANA membership or AANA Nonmember Recordkeeping.
- **A reinstatement fee of \$500.00** will be assessed for any application that is incomplete or received after July 31, 2010.
- Each payment must be accompanied by a check or credit card payment information. Single payment for multiple applications will not be accepted.
- Make checks payable to the National Board on Certification and Recertification of Nurse Anesthetists.

**C. RN and APRN License**

- Copy of your current license to practice as a registered nurse in all the states listed on the record of practice since August 1, 2008.
- Copy of your advanced practice nursing credential if required by your State Board of Nursing for any of the states listed on your record of practice since August 1, 2008.
- The RN and APRN licenses must be current and the expiration date and the state board of nursing must clearly show on the copy.
- Copies of Web RN and APRN verifications may be submitted in lieu of a paper license.

**D. Continuing Education**

- 40 CE credits earned from August 1, 2008 to July 31, 2010.
- The AANA transfers credits on file to the Council on Recertification for current AANA members and nonmembers with AANA Recordkeeping. **All other applicants must submit documentation of CE credit directly to the Council.** Refer to *Directions for Documentation of CE Credits for Recertification*, enclosed with this application or available on the NBCR NA website, www.nbcna.com, under RESOURCES.

**E. Certification of the Applicant**

- Certify to the following by placing a check in the corresponding box. If you cannot so certify, submit a written explanation and copies of any relevant documents with your application.

**By checking the box below, I certify that:**

- I do not currently suffer from a mental or physical condition which might interfere with the practice of nurse anesthesia;
- I do not currently suffer from drug or alcohol addiction or abuse;
- I have not been convicted of and am not currently under indictment for any felony;
- My RN and/or APRN license has never been revoked, restricted, surrendered, suspended or limited by any state, and is not the subject of a pending action or investigation except those actions or pending actions that previously were disclosed to the Council;
- I have not been the subject of any documented allegations of misconduct, incompetent practice or unethical behavior;
- My record of practice is accurate and I have been or will have been substantially engaged in the practice of nurse anesthesia during the two-year period prior to my upcoming August 1 recertification date; and
- My statements on this application are true, accurate and complete to the best of my knowledge.

***Intentional misstatement of a material fact or deliberate failure to provide relevant information to the NBCR NA may result in a denial or revocation of recertification.***

<b>Fee Paid</b> <input type="checkbox"/> \$100 _____	<b>Office Use Only</b>
<b>CE Processing Fee</b> <input type="checkbox"/> \$300 _____	
<b>Reinstatement Fee</b> <input type="checkbox"/> \$500 _____	
<b>Late Start Date:</b> _____	

## Criteria for Recertification, Section B-4, Practice Requirement

Certification by the applicant that he or she has been or will have been substantially engaged in the practice of nurse anesthesia during the two-year period prior to the applicant's upcoming August 1 recertification date. It is recommended that substantial engagement in the practice of nurse anesthesia generally should consist of a minimum of 850 hours of practice over the two-year recertification period.

Because individual practice experiences vary it is the responsibility of the applicant to assess whether his or her practice experience constitutes substantial engagement and to so certify. The practice of nurse anesthesia may include clinical practice, anesthesia-related administrative, educational or research activities, or a combination of two or more such areas of practice. To be anesthesia related, activities must have as their primary objective and be directly related to the delivery of anesthesia care to patients and/or the improvement of delivery of anesthesia care to patients.

Where there is an inconsistency between the applicant's practice certification and his or her record of practice, and/or other information received by the Council, the decision as to whether an applicant has satisfied the practice requirement is at the discretion of the NBCRNA.

- List the facilities at which you have substantially engaged in the clinical practice of nurse anesthesia or performed anesthesia-related administrative, educational, or research services since **August 1, 2008**. Include the **month** and **year** for the dates of practice at each facility, as well as facility address, contact person and phone number to verify practice for each facility.
- Do not use the name of an employment agency, registry, locum tenens placement service or business. You must provide the name of each facility at which you have practiced since **August 1, 2008**.
- If you have practiced in more than one state, you must provide a copy of the RN and/or advanced practice credential for each state shown on the record of practice for the period since **August 1, 2008**.
- *Provisional Recertification Eligibility.* If you are **currently able** to practice nurse anesthesia and have not practiced substantially for more than two years but have practiced within three years prior to July 31, 2010, complete a record of practice for the past three year period if you want to be considered for recertification.

**Any missing information will cause this application to be returned and processing of your recertification to be delayed.**

### 1. Name of Facility: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code + 4 \_\_\_\_\_

Dates of Practice: From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Check one:  Part time  Full time  
Month Year Month Year

Facility contact person \_\_\_\_\_ Facility phone number \_\_\_\_\_  
Area Code

CRNA Position:  Practitioner  Educator  Administrator  Researcher  Other \_\_\_\_\_

If applicable, indicate specialization (8 or more practice hours per week) in one of the following practice areas:  
 Pain Management  Obstetrics  Pediatrics  Cardiac  Neurosurgery

### 2. Name of Facility: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code + 4 \_\_\_\_\_

Dates of Practice: From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Check one:  Part time  Full time  
Month Year Month Year

Facility contact person \_\_\_\_\_ Facility phone number \_\_\_\_\_  
Area Code

CRNA Position:  Practitioner  Educator  Administrator  Researcher  Other \_\_\_\_\_

If applicable, indicate specialization (8 or more practice hours per week) in one of the following practice areas:  
 Pain Management  Obstetrics  Pediatrics  Cardiac  Neurosurgery

### 3. Name of Facility: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code + 4 \_\_\_\_\_

Dates of Practice: From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Check one:  Part time  Full time  
Month Year Month Year

Facility contact person \_\_\_\_\_ Facility phone number \_\_\_\_\_  
Area Code

CRNA Position:  Practitioner  Educator  Administrator  Researcher  Other \_\_\_\_\_

If applicable, indicate specialization (8 or more practice hours per week) in one of the following practice areas:  
 Pain Management  Obstetrics  Pediatrics  Cardiac  Neurosurgery

# Application for Recertification

AANA ID # \_\_\_\_\_

## WAIVER OF LIABILITY AND HOLD HARMLESS STATEMENT

### Each applicant for recertification is required to sign the following statement:

I hereby request the National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA), Council on Recertification of Nurse Anesthetists to review my application for recertification and grant me recertification as a Certified Registered Nurse Anesthetist, in accordance with and subject to the procedures and regulations of the Council. I have read and agree to the requirements and conditions set forth in the *Criteria for Recertification* and I agree to abide by those requirements and conditions. I agree to denial of recertification, and to forfeiture and redelivery of any recertification card issued to me by the Council in the event that any of the statements or answers made by me in this application are false or in the event that I am no longer in compliance with the recertification criteria.

I hereby agree to hold the NBCRNA, the Council on Recertification of Nurse Anesthetists, and their members, officers, employees, and agents, harmless from any complaint, claim, or damage arising out of any action or omission by any of them in connection with this application, the application process, the failure to issue me any recertification card, or any demand for forfeiture or redelivery of such recertification card. I understand that the decision as to whether I qualify for recertification rests solely and exclusively with the NBCRNA and that the decision of the NBCRNA is final. I HAVE READ AND UNDERSTAND THIS STATEMENT AND I INTEND TO BE LEGALLY BOUND BY IT.

I \_\_\_\_\_ hereby certify that all of the information submitted on this form is true.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## APPLICATION FEES

- |   |                 |
|---|-----------------|
| <input type="checkbox"/> <b>Application Fee</b>   | <b>\$100.00</b> |
| <input type="checkbox"/> <b>CE Credit Processing Fee</b><br><i>(Required in addition to the application fee for applicants who must submit documentation of CE credit directly to the Council on Recertification)</i> | <b>\$300.00</b> |
| <input type="checkbox"/> <b>Reinstatement Fee</b><br><i>(Required for applications that are incomplete or received after July 31, 2010)</i>   | <b>\$500.00</b> |

**TOTAL PAYMENT:** \$ \_\_\_\_\_

### Choose Method of Payment:

- My check for \$ \_\_\_\_\_ is enclosed — Check # \_\_\_\_\_ Make check payable to: **National Board on Certification and Recertification of Nurse Anesthetists**
- I will pay using the following credit card:  Mastercard  Visa  Amer Express
- Amount \$ \_\_\_\_\_ Cardholder Name \_\_\_\_\_

**Include the 3-digit security code located on the signature space of your card.**

Card # \_\_\_\_\_ 3-Digit Security Code \_\_\_\_\_ Exp. Date \_\_\_\_ / \_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_