



Application for Recertification of School Nurses through Continuing Education

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided. →

A	B	C	D	E	F	1	2	3	4	5	6
---	---	---	---	---	---	---	---	---	---	---	---

Candidate Information

Last Name

First Name

Middle Initial

Number and Street

Apartment Number

City

State/Province

Zip/Postal Code

Daytime Phone
 - -

Evening Phone
 - -

Email Address

Date of Initial Certification
 /

Month Year

Date of Most Recent Certification (if applicable)
 /

Month Year

Most Recent NCSN Certificate Number (required)

Current RN License Number:

License State:

License Expiration (Month/Year)
 /

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. PERCENT OF WORKING TIME CURRENTLY SPENT IN SCHOOL NURSING:

- Less than 25% 51 to 75%
 25% to 50% More than 75%

B. PRESENT POSITION IN SCHOOL NURSING:

- Staff Nurse Consultant
 Supervisor Other
 Administrator

C. EXPERIENCE IN SCHOOL NURSING:

- 3 years 6 - 10 years
 4 - 5 years More than 10 years

D. PRIMARY PRACTICE SETTING:

- Preschool
 Elementary School
 Middle-Junior High School
 Senior High School
 Combination or multilevel
 Other

E. PRIMARY PRACTICE EMPHASIS:

- Regular Education
 Special Education
 Funded Assessment Programs
 (EPSDT, Chapter 1, Migrant Program, etc.)
 Other

F. ARE YOU A MEMBER OF A FORMALIZED MULTISDISCIPLINARY EARLY INTERVENTION/PUPIL EVALUATION/CHILD STUDY OR SPECIAL EDUCATION TEAM/IEP?

- No Yes

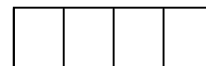
G. IS YOUR PERFORMANCE EVALUATION CONDUCTION BY A RN ADMINISTRATOR?

- No Yes

H. ARE YOU SUPERVISED BY A RN ADMINISTRATOR IN YOUR WORKING SETTING?

- No Yes

(Continue on page 2)



Application for Recertification of School Nurses through Continuing Education



Eligibility and Background Information

I. PROFESSIONAL NURSING BACKGROUND:

- General Nursing
- Public or Community Health
- Pediatrics
- Maternal and Child Health
- Mental Health
- Other

J. ARE YOU A MEMBER OF YOUR STATE SCHOOL NURSE ASSOCIATION?

- No
- Yes

K. TYPE OF NURSE PRACTITIONER:

- Not a Nurse Practitioner
- School Nurse Practitioner
- Pediatric Nurse Practitioner
- Maternal Nurse Practitioner
- Community Nurse Practitioner
- Family Nurse Practitioner
- Other Nurse Practitioner

L. HIGHEST ACADEMIC LEVEL:

- Associate Degree in Nursing
- Diploma in Nursing
- Bachelor's Degree in Nursing
- Bachelor's Degree (non-Nursing)
- Master's Degree in Nursing
- Master's Degree (non-Nursing)
- Doctoral Degree

M. ARE YOU A MEMBER OF NASN?

- No Yes
- (Note: Membership in NASN is not required.)

N. ARE YOU CERTIFIED IN NURSING BY ANY ORGANIZATION OTHER THAN NCSN?

- No Yes

O. ARE YOU CERTIFIED IN NURSING BY YOUR STATE BOARD OF EDUCATION?

- No Yes

P. RECORD TOTAL NUMBER OF CE HOURS FROM PAGE 4.

TOTAL CE HOURS:

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your recertification.

Race

- African American
- Asian
- Hispanic
- Native American
- White
- No Response

Age Range:

- Under 25
- 25 to 29
- 30 to 39
- 40 to 49
- 50 to 59
- 60+

Gender:

- Male
- Female

COMPLETE ALL FOUR PAGES OF THE APPLICATION BEFORE SIGNING BELOW.

Candidate Signature

I have read the Guidelines for Recertification and understand I am responsible for knowing its contents. I certify that the information given in this Application is in accordance with Guidelines and is accurate, correct, and complete.

CANDIDATE SIGNATURE: _____ DATE: _____

CREDIT CARD PAYMENT

If you want to charge your application fee on your credit card provide all of the following information.

Name (as it appears on your card): _____

Address (as it appears on your statement): _____

Charge my credit card for the total fee of: \$

Card type: Visa MasterCard American Express

Expiration date (month/year): /

Card Number:

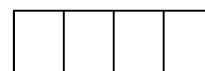
Signature: _____

FOR OFFICE USE ONLY

Date

Fee:

CC Check



B. ACADEMIC COURSES (Each individual academic credit will be considered as ten (10) Contact Hours and may be at undergraduate or graduate level. A transcript of successful course completion must be submitted. List course in date order, beginning with the most recent. **Print or type** all information.)

Month/Year Completed	Institution (Name & State)	Course Title	Course Credits	Equivalent Contact Hours (Credit x 10)

ENTER TOTAL NUMBER OF EQUIVALENT CONTACT HOURS FROM ACADEMIC COURSES _____

C. MISCELLANEOUS ACTIVITIES (This may include the preparation and presentation of a professional education topic relevant to school health; the participation in a two-day NBCSN item review session; Professional Activities, Precepting Student Nurses; or Submission of 15 items for the examination - Each for 5 Contact Hours. An original article written by the candidate and published in a professional journal earns 10 Contact Hours. Provide information listed in guidelines.)

Month/Year Completed	Activity	Contact Hours

ENTER TOTAL NUMBER OF EQUIVALENT CONTACT HOURS FROM MISCELLANEOUS ACTIVITIES _____

D. Before signing Candidate Affirmation, PRINT your name and number exactly as they appear on your current certificate

ENTER TOTAL CONTACT HOURS FROM PAGES 3 AND 4 HERE → **AND ON THE BOXES INDICATED AT THE TOP RIGHT OF PAGE 2, ROUNDING TO THE NEAREST WHOLE NUMBER.**

Name (PRINT) NCSN Number

E. CANDIDATE AFFIRMATION/AUTHORIZATION

I affirm that all statements given on this Application are true and correct to the best of my knowledge and that the NBCSN is hereby authorized to contact any organization or individual listed hereon to verify my continuing education history.

Current Registered Nurse License Number

Signature of NCSN Date

******APPLICATION CHECK LIST******

- ____ Pages 1, 2, 3 and 4; completed and signed
- ____ Certificates for Contact Hours
- ____ Fee (\$225) enclosed
- ____ Documentary proof of current employment
- ____ Copy of current RN license

MAIL APPLICATION AND DOCUMENTS TO:
NBCSN RECERTIFICATION
1350 BROADWAY, 17th FLOOR
NEW YORK, NY 10018