Congratulations on your decision to become certified, or retain your certification, in Radiologic Nursing in Imaging, Interventional, and Therapeutic Environments. Please visit www.certifiedradiologynurse.org to download the Guidelines for Certification & Recertification to assist you in preparing your application materials.

Incomplete application packets will not be processed*. A complete application packet includes the following items:

- Fully completed certification/recertification application form-for exam date and exam site visit www.certifiedradiologynurse.org
- Proof of current ARIN Membership with expiration date (if applies)-printed screenshot from www.arinursing.org is acceptable
- Copy of current nursing license -printed screenshot showing name and expiration date from licensing body is acceptable
- Completed contact hour documentation form included with application (page 4). If you prefer a workable Excel file you can download it at www.certifiedradiologynurse.org
- Copies of each certificate for the items documented on the contact hour documentation form; certificates must include the activity approval number, date completed, and the name of the contact hour approver or provider
- Appropriate payment amount, including any late fees that apply (see www.certifiedradiologynurse.org for late fee dates that may apply)
- Signed cover letter with payment included

Fees

<table>
<thead>
<tr>
<th>Certification</th>
<th>Recertification</th>
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</thead>
<tbody>
<tr>
<td>ARIN Members-$300</td>
<td>ARIN Members-$300</td>
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<tr>
<td>NON MEMBERS-$425 (Application Fee $25)</td>
<td>NON MEMBERS-$425 (Application Fee $25)</td>
</tr>
<tr>
<td>(Examination Fee $275) (Application Fee $400)</td>
<td>(Examination Fee $275) (Application Fee $400)</td>
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<tr>
<td>ARIN Expiration Date</td>
<td>Recertification Fee $275 Recertification Fee $400</td>
</tr>
</tbody>
</table>

FIRST TIME RETEST CERTIFICATION LAPSED

- Late Fee: $45 Exam applications received up to 14 days past application deadline
- Late Fee: $125 Recertification applications received less than 60 days prior to certification expiration date

The late fee must be included with registration after the established deadlines (see www.certifiedradiologynurse.org). Application fee, late fee and special fees are non-refundable and non-transferable to another year. **The cancelled postmark will be used for the date the application is submitted.**

Payment Method:

- Personal Check/Money Order (Payable to RNCB) Amount enclosed: ____________________________
- Charge Card (Amount to be charged): ________________
- Master Card   Visa   American Express
- Card #__________________________ Exp. Date_________________ CVV#_________________

Signature on this Account: ______________________________________________________________________________

By signing this cover letter to accompany my application for certification/recertification I acknowledge that incomplete applications will not be accepted, and I will be notified that the application and any payment form will be shredded. I acknowledge that if my application is not accepted I may resubmit when I have completed the missing documentation and that I will be responsible for any late fees that may apply at the time I resubmit.

Printed Name______________________________________________________________________________________

Signature_________________________________________________________ Date___________________________

*Keep a copy of your entire application packet for your records. Incomplete applications will not be processed. You will be notified that the application has not been accepted and that the application packet, including payment, will be shredded.

Mail completed application packets to: RNCB, 7794 Grow Drive, Pensacola, FL 32514-7072
Questions: 855-871-6681 or RNCB@internationalamc.com
RADIOLOGIC NURSING CERTIFICATION BOARD (RNCB®)

Certification Examination for Radiologic Nursing in Imaging, Interventional, and Therapeutic Environments

Application materials that are illegible, incomplete, or not accompanied by the proper fee and appropriate documentation will be returned.

<table>
<thead>
<tr>
<th>PERSONAL DATA</th>
<th>Please print or type your name as you would like it to appear on your certificate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Number and Street</td>
<td>City</td>
</tr>
<tr>
<td>Country (if other than USA)</td>
<td>E-mail Address</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Office Phone</td>
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</tbody>
</table>

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<tr>
<th>APPLICATION FOR:</th>
<th>(Please Indicate)</th>
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</thead>
<tbody>
<tr>
<td>CERTIFICATION</td>
<td>FIRST TIME</td>
</tr>
<tr>
<td>Exam Date Requested:</td>
<td>(see <a href="http://www.certifiedradiologynurse.org">www.certifiedradiologynurse.org</a>)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECERTIFICATION</th>
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</thead>
<tbody>
<tr>
<td>Expiration Date</td>
<td>Initial Certification Date</td>
</tr>
<tr>
<td>Name on previous application if different from this one</td>
<td></td>
</tr>
<tr>
<td>Are you certified by another organization?</td>
<td>Yes</td>
</tr>
<tr>
<td>If so, indicate certification and Organization:</td>
<td></td>
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</tbody>
</table>

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<tr>
<th>LICENSURE INFORMATION</th>
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<tbody>
<tr>
<td>1. CURRENT LICENSURE</td>
</tr>
<tr>
<td>RN License Number</td>
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<tr>
<td>2. Submit a photocopy of your current license with this application; printed website screenshots from your licensing state are acceptable if you do not have a card.</td>
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<tr>
<th>VERIFICATION OF PROFESSIONAL QUALIFICATIONS</th>
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<tbody>
<tr>
<td>Two responsible practitioners in the specialty area must verify that the applicant meets the radiology nursing practice requirements below:</td>
</tr>
<tr>
<td>1. Have practiced as a licensed registered nurse a minimum of 2,000 hours in radiology nursing practice within the past 3 years for certification. Have practiced as a licensed registered nurse a minimum of 2,000 hours in radiology nursing practice within the past 4 years for recertification.</td>
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<tr>
<td>-and-</td>
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<tr>
<td>2. Have been engaged in radiology nursing practice an average of 8 hours per week.</td>
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</table>

These eligibility requirements may be met if you have been engaged in direct patient care or direct clinical management, supervision, education, or direction of other persons to achieve or help achieve patient/client goals for the stated number of hours.

Name _______________ Name _______________
Title _______________ Title _______________
Institution _______________ Institution _______________
City _______________ State _______________ City _______________ State _______________
Signature _______________ Date ________ Signature _______________ Date ________
Contact Phone Number __________________ Contact Phone Number __________________
DEMOGRAPHICS

Please fill in the box for ALL levels of education completed:

01  □ Diploma
02  □ Associate Degree in Nursing
03  □ Baccalaureate in Nursing
04  □ Baccalaureate in Other Field
05  □ Master's in Nursing
06  □ Master's in Other Field
07  □ PhD in Other Field
08  □ EdD
09  □ DNSc
10  □ PhD in Nursing

a. Undergraduate Institution: ________________________
   Major: __________________________
   Date Degree Completed: ________________

b. Graduate Institution: __________________________

Sex:  □ Male  □ Female

Primary field/place of employment (check one box):

01  □ Hospital
02  □ Nursing Home/Long Term Care
03  □ Home Health
04  □ Nurse Managed Practice Group Center
05  □ Private Practice
06  □ Public Health
07  □ School Health
08  □ Office Nursing (Physician/Dentist)
09  □ Occupational Health
10  □ Clinic (Specify): _________________________
11  □ Group Practice
12  □ School of Nursing
13  □ Other (Specify): _________________________

Primary Position (check one box):

01  □ Head Nurse or Assistant
02  □ Staff Nurse
03  □ Nurse Practitioner
04  □ Clinical Specialist (Master's degree or above)
05  □ Nursing Administrator
06  □ Associate or Assistant Administrator
07  □ Supervisor or Assistant Supervisor
08  □ Educator
09  □ Consultant
10  □ Researcher
11  □ Other (Specify): _________________________

Years of Experience as a registered nurse:

1  □ 0-2   5  □ 16-20
2  □ 3-5   6  □ 21-25
3  □ 6-10  7  □ 26-30
4  □ 11-15 8  □ Over 30

Total years of experience in the field of radiology nursing:

1  □ 0-2   5  □ 16-20
2  □ 3-5   6  □ 21-25
3  □ 6-10  7  □ 26-30
4  □ 11-15 8  □ Over 30

Size of facility (total number of beds):

1  □ N/A   4  □ 251-500
2  □ 1-100 5  □ Over 500
3  □ 101-250

Location of facility:

1  □ Urban   2  □ Rural

STATEMENT OF UNDERSTANDING:

I hereby apply for certification offered by the Radiologic Nursing Certification Board (RNCB®). I understand that I am subject to all requirements of certification as described in the Guidelines for Certification and Recertification and that certification depends on successfully completing specified program requirements. If certified, my name will be included on the official listing of certified nurses.

I authorize the RNCB® to make whatever inquiries and investigations that it deems necessary to verify my credentials, professional standing, and participation in continuing education. Information accumulated by RNCB® through the certification process may be used for statistical purposes and for evaluating the program. All information will be kept confidential and shall not be used for any other purposes without my permission.

To the best of my knowledge, the information on this application is complete and accurate. I attest by my signature that I meet all eligibility requirements for certification as stipulated in the Guidelines for Certification and Recertification in effect for the year in which this application is made. I attest by my signature that I will maintain active RN licensure throughout the entire period during which I am certified. I understand that misstatement of any material fact submitted upon application for certification may be sufficient cause for RNCB® to bar me from the examination, to invalidate the results of my examination, to withhold certification, to revoke certification, or to take other appropriate action.

Signature: _______________________________________

Date: __________________________________________

Mail the cover letter, application, RNCB® Continuing Education Documentation Form, and supporting materials to RNCB, 7794 Grow Drive, Pensacola, FL 32514.

If you have questions about the application process or required documentation call 855-871-6681 or e-mail RNCB@internationalamc.com

If you have questions about the test, exam sites, or dates, contact the testing center: C-NET, 35 Journal Square, Suite 901, Jersey City, NJ 07306 or (800) 463-0786 or visit www.cnetnurse.com
radiologic nursing certification board (rncb®)
continuing education documentation form

applicant name:

applications for certification must document 30 contact hours within 2 years of the exam date; a minimum of 15 must be radiology specific.

submission date

applications for recertification must document 60 contact hours within 4 years of your expiration date, with a minimum of 30 being radiology specific.

<table>
<thead>
<tr>
<th>date of education</th>
<th>contact hours received</th>
<th>indicate if radiology specific or general nursing</th>
<th>contact hour approval: name of accrediting provider. example asrt, ancc, arin</th>
<th>course number and/or title</th>
<th>if radiology specific describe how it is pertinent to the care of your patient</th>
<th>accepted (completed by rncb® reviewer)</th>
<th>comments (completed by rncb® reviewer):</th>
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please copy as needed for additional documentation. return this form with certification/recertification application and all supporting documentation