

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.

| | | | |
|---|-------------------|-----------------------|-----------------|
| PERSONAL DATA Please print or type your name as you would like it to appear on your certificate. | | | |
| _____ | | _____ | |
| Last Name | First Name | MI | |
| _____ | | _____ | |
| Number and Street | City | State | Zip Code |
| _____ | | _____ | |
| Country (if other than USA) | | E-mail Address | |
| _____ | | _____ | |
| Home Phone | | Office Phone | |
| _____ | | _____ | |

APPLICATION FOR: (Please Indicate)

- CERTIFICATION** **FIRST TIME** **RETEST** **RETEST CERTIFICATION LAPSED**
Exam Date Requested: _____ (see www.certifiedradiologynurse.org)
Exam Site Requested: _____ (see www.certifiedradiologynurse.org)

- RECERTIFICATION**
Expiration Date _____ Initial Certification Date _____
Name on previous application if different from this one _____
Are you certified by another organization? Yes No If so, indicate certification and Organization: _____

LICENSURE INFORMATION

- CURRENT LICENSURE**
RN License Number _____ State: _____ Exp. Date: _____
- 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.

VERIFICATION OF PROFESSIONAL QUALIFICATIONS

Two responsible practitioners in the specialty area must verify that the applicant meets the radiology nursing practice requirements below:

- 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.

-and-

- Have been engaged in radiology nursing practice an **average** of 8 hours per week.

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

Total years of experience in the field of radiology nursing:

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

Size of facility (total number of beds):

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

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

