ANVP® Application Checklist

Name: ____

**REQUIRED**

- [ ] Application form
- [ ] Verification of work experience form
- [ ] Check or money order made payable to ANVC
- [ ] Supervisor signature of license verification
- [ ] Continuing Education forms
- [ ] Demographics form

Total CE submitted: ____
ANVP® RECERTIFICATION APPLICATION  
OPTION 2: RECERTIFICATION BY CONTINUING EDUCATION

Complete all sections of the application by double clicking on gray boxes below

Name as you would like it to appear on the certificate (type): ______

Name as it appeared on initial certification, IF DIFFERENT from requested recertification name: ______

Year of initial certification: ______

Current certification # ______

Street Address _____ City _____ Country _____ State or Province _____ Zip/Postal Code _____

Check here if this is a new address from time of initial certification

Work Position/Title_____

Home Telephone (including country code & area code) ______
Mobile Telephone (including country code & area code) ______

E-mail Address _____

Continuing Education (CE) Summary:
List below the total number of CE earned in each of the categories listed below. All candidates for recertification must present a minimum of 30 CE in category 1.

<table>
<thead>
<tr>
<th>Category</th>
<th>CE Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: CE or College Credit for Courses Pertinent to Neurovascular Clinical Practice</td>
<td></td>
</tr>
<tr>
<td>2: Program/Project Activities to Improve the Quality of Neurovascular Care</td>
<td></td>
</tr>
<tr>
<td>3: Neurovascular Research</td>
<td></td>
</tr>
<tr>
<td>4: Provision of Formal Neurovascular Education</td>
<td></td>
</tr>
<tr>
<td>5: Published Neurovascular Scientific Papers</td>
<td>Minimum Total of 100 CEUs Required</td>
</tr>
</tbody>
</table>

Clinical Practice Eligibility Documentation:
I attest that during the past three (3) years I have been actively and directly involved in the care of neurovascular patients, or in management, education or research directly related to neurovascular practice, completing at least 3,000 hours/three years. I further affirm that I am currently licensed to practice my advanced role in the state/district of ______ in the country of ______. I further affirm that no licensing authority has taken any disciplinary action in relation to my license to practice in the aforementioned or any other state/district or country, and that my license to practice has not been suspended or revoked by any state or jurisdiction. I further affirm that all information in this application is true and correct.

Applicant’s Signature ___________________________ Date __________________

Statement of Supervisor
I hereby affirm that I am the current supervisor of the ANVP named above, and attest to his/her right by licensure to practice in an advanced role; the applicant has completed a total of 3,000 practice hours in neurovascular practice over the past 3 years.

Name of Immediate Supervisor (print) ___________ Signature __________________ Date __________________

Email Address: ______ Email Address: ______ Email Address: ______

Position Title _____ Institution ______

Business Street Address _____ City _____ State _____ Zip Code _____
## ANVP RECERTIFICATION OPTION 2
### Category 1 Hours

Continuing Education Credit and/or College Credit

<table>
<thead>
<tr>
<th>Date and Year of Program</th>
<th>Full Name of Organization Providing Program OR Course (do not use initials)</th>
<th>Full Name of Continuing Education Credit or College Credit Provider</th>
<th>Title of Programs OR Courses</th>
<th>Number of Approved Hours</th>
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</thead>
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</tbody>
</table>

Subtotals for this page:

Name _____ Page _____ of _____

Category 1 CE Total: _____

*This page may be duplicated as needed to provide additional pages to capture all CE credit.*
**ANVP RECERTIFICATION OPTION 2**  
**Category 2 Hours**

Program/Project Activities to Improve the Quality of Neurovascular Care

<table>
<thead>
<tr>
<th>Date and Year</th>
<th>Title of Program or Project</th>
<th>Number of Approved Hours</th>
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<tbody>
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Subtotals for this page:  

Name _____  Page _____ of _____  

Category 2 CE Total:  

_This page may be duplicated as needed to provide additional pages to capture all project hours._
# ANVP RECERTIFICATION OPTION 2
## Category 3 Hours

### Neurovascular Research

<table>
<thead>
<tr>
<th>Date and Year</th>
<th>Title of Research Study</th>
<th>Number of Approved Hours</th>
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<tbody>
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**Subtotals for this page:**

Name _____ Page _____ of _____  
Category 3 CE Total: _____

*This page may be duplicated as needed to provide additional pages to capture all project hours.*
**ANVP RECERTIFICATION OPTION 2**  
Category 4 Hours  

Provision of Formal Neurovascular Education

<table>
<thead>
<tr>
<th>Date and Year</th>
<th>Title of Course or Presentation</th>
<th>Number of Approved Hours</th>
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</tbody>
</table>

Subtotals for this page:  

Name _____ Page _____ of _____  
Category 4 CE Total: _____  

*This page may be duplicated as needed to provide additional pages to capture all project hours.*
## ANVP RECERTIFICATION OPTION 2
### Category 5 Hours

Scientific Neurovascular Publications

<table>
<thead>
<tr>
<th>Date and Year of Program</th>
<th>Full Medline (PubMed) Citation</th>
<th>Number of Approved Hours</th>
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<tbody>
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Subtotals for this page: ___

Name ____ Page ____ of ____

Category 5 CE Total: ___

This page may be duplicated as needed to provide additional pages to capture all project hours.
Association of Neurovascular Clinicians Certification Program

Candidate Demographic Data

To assist ANVC in identifying aggregate characteristics of certified neurovascular clinicians, please complete this demographic data form. This information is used for statistical purposes only and does not affect eligibility for certification. While we would appreciate receiving all information, you may omit information that you are uncomfortable providing. This part of the application will be separated from other materials upon receipt in the ANVC Office, and is not used in certification eligibility decision making.

Primary practice focus (select only one):
- Neuro-Telemetry and/or Stroke Unit
- Neuro-ICU
- Mixed Critical Care
- Emergency Department

Highest Educational Degree (select only one):
- RN Diploma
- BSN or BS
- DNP
- PhD
- Associate Degree
- MS/MSN
- Other (please specify) ______________________

Work Function (select all that apply):
- Administrator
- Clinical Nurse Specialist
- Nurse Practitioner
- Clinical Manager
- Consultant
- Researcher
- Clinical Educator
- Academic Faculty
- Staff Nurse
- Physician Assistant
- Stroke Coordinator
- Service Line Manager
- Other (specify) ___________________________

Primary Work Setting (select one):
- College or university
- University/teaching hospital
- Private physician practice
- Community hospital
- Outpatient clinic
- Rehabilitation facility
- Other (please specify) ____________________

Years in neurovascular care:
- 2-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- More than 20 years

Reason you are seeking certification (check all that apply)
- Professional recognition
- Personal recognition
- Job requirement
- Financial reward (such as bonus)
- Other (specify) ___________________________

In what country did you do your training?
- United States
- Other (specify) ___________________________