

ANVP® Application Checklist

Name: _____

REQUIRED

- Application form
- Verification of work experience form
- Recertification payment receipt (pay by credit card by visiting www.anvc.org/recertification)
We also accept check or money order made payable to ANVC
- Supervisor signature of nursing 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.

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

Clinical Practice Eligibility Documentation:

I attest that during the past five (5) 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 1,000 hours/five 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 _____

Only applications signed by hand will be accepted

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 1,000 practice hours in neurovascular practice over the past 5 years.

Name of Immediate Supervisor (print) _____

Signature _____

Email Address: _____

Date _____

Position Title _____ Institution _____

Business Street Address _____ City _____ State _____ Zip Code _____

ANVP RECERTIFICATION OPTION 2 Category 1 Hours

Continuing Education Credit and/or College Credit

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

Subtotals for this page: _____

Category 1 CE Total: _____

Name _____ Page _____ of _____

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

Date and Year	Title of Program or Project	Number of Approved Hours

Subtotals for this page: _____

Category 2 CE Total: _____

Name _____ Page _____ of _____

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

Date and Year	Title of Research Study	Number of Approved Hours

Subtotals for this page: _____

Category 3 CE Total: _____

Name _____ Page _____ of _____

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

Date and Year	Title of Course or Presentation	Number of Approved Hours

Name ____ Page ____ of ____

Subtotals for this page: _____

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

Date and Year of Program	Full Medline (PubMed) Citation	Number of Approved Hours

Subtotals for this page: _____

Category 5 CE Total: _____

Name _____ Page _____ of _____

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 Mixed Critical Care
 Neuro-ICU 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 year 11-15 years More than 20 years
 6-10 years 16-20 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) _____