

**Association of Neurovascular Clinicians Certification Program**

**Please do not leave any section unanswered or your application may be denied.**

I am applying for the examination certification of **Advanced Stroke Coordinator (ASC-BC)**

**Name as you wish it to appear on the certificate:**

**Title:**       **Credentials:**

**Home Mailing Address:**

**City:**       **State:**       **Zip Code:**

**Daytime Phone:**       **E-mail:**

**Supervisor name:**

**Supervisor Title:**

**Supervisor Email Address:**

**Place of Employment:**

**Employment Mailing Address:**

**City:       State:       Zip Code:**

**Daytime Phone:**

|  |  |
| --- | --- |
|       | By initialing this box, I am providing my electronic signature affirming that all the information entered above is accurate and complete. I further affirm that I am currently licensed to practice as a nurse in the state of       License #       *(this is not a requirement – however if you wish to receive nursing CEUs – please provide).* I agree to release this application page for audit/employment verification purposes. I agree to give ANVC permission to publish my name, credentials, and place of employment on the website.  |
|       | Date  |
|       | Signature |