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](http://www.anvc.org/recertification))

*We also accept 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.

|  |  |
| --- | --- |
| **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: Professionalism |  |
| 4: Neurovascular Research |  |
| 5: Provision of Formal Neurovascular Education |  |
| 6: Published Neurovascular Scientific Papers |  |
| *Minimum Total of 100 CEUs Required* |  |

**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 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 *OR* Courses | **Number of Approved Hours** |
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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

|  |  |  |
| --- | --- | --- |
| **Date and Year** | Title of Program or Project | **Number of Approved Hours** |
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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

**Professionalism**

|  |  |  |
| --- | --- | --- |
| **Date and Year** | Title of Research Study | **Number of Approved Hours** |
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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

**Neurovascular Research**

|  |  |  |
| --- | --- | --- |
| **Date and Year** | Title of Course or Presentation | **Number of Approved Hours** |
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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

**Provision of Formal Neurovascular Education**

|  |  |  |
| --- | --- | --- |
| **Date and Year** | Title of Course or Presentation | **Number of Approved Hours** |
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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.*

ANVP RECERTIFICATION OPTION 2

Category 6 Hours

**Scientific Neurovascular Publications**

|  |  |  |
| --- | --- | --- |
| **Date and Year of Program** | **Full Medline (PubMed) Citation** | **Number of Approved Hours** |
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Subtotals for this page:

Name Page of  **Category 6 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  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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_