NVRN® Application Checklist

Name: ____

**REQUIRED**

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

Total CE submitted: ____
NVRN® 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): ______

Previous Name if different from initial certification: ______

Year of initial certification: ______

Current certification #: ______

Street Address _____ City_____ State _____Zip _____

☐ 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 Nursing</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 Paper</td>
<td></td>
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</tbody>
</table>

Minimum Total of 100 CEUs Required

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 nursing, completing at least 5,000 hours/five years.
I further affirm that I am currently licensed to practice nursing in the state/district of _____ in the country of _____.
I further affirm that no nursing licensing authority has taken any disciplinary action in relation to my license to practice nursing in the aforementioned or any other state/district or country, and that my license to practice nursing 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 nurse named above, and attest to his/her right by licensure to practice professional nursing; the applicant has completed a total of 5,000 practice hours in neurovascular nursing over the past 5 years.

Name of Immediate Supervisor (print) ____________________________

Email Address: _____________________________________________ Date __________________________

Position Title _____ Institution ______

Business Street Address _____ City _____ State _____ Zip Code _____
## NVRN 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>
</tr>
</thead>
</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.*
## NVRN 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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</tbody>
</table>

**Total 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.*
### 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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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.
## NVRN 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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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.
<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>
</table>

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-Telometry and/or Stroke Unit
- [ ] Neuro-ICU
- [ ] Mixed Critical care
- [ ] Emergency Department

Highest Educational Degree (select only one):
- [ ] RN Diploma
- [ ] BSN or equivalent
- [ ] DNP
- [ ] PhD
- [ ] Associate Degree
- [ ] MS/MSN
- [ ] Other (please specify):
  __________________________

Work Function (select all that apply):
- [ ] Administrator
- [ ] Clinical Nurse Specialist
- [ ] Nurse Practitioner
- [ ] Case manager
- [ ] Consultant
- [ ] Researcher
- [ ] Clinical Educator
- [ ] Academic Faculty
- [ ] Staff Nurse
- [ ] Physician Assistant
- [ ] Stroke Coordinator
- [ ] Other (specify):
  __________________________

Primary Work Setting (select one):
- [ ] School of nursing
- [ ] 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
- [ ] More than 15 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):
  __________________________