

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.

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

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 nursing, completing at least 3,000 hours/three 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 _____

Only applications signed by hand will be accepted

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 3,000 practice hours in neurovascular nursing over the past 3 years.

Name of Immediate Supervisor (print) _____

Signature _____

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

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.

NVRN 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: _____

Name _____ Page _____ of _____

Category 2 CE Total: _____

This page may be duplicated as needed to provide additional pages to capture all project hours.

NVRN RECERTIFICATION OPTION 2
Category 3 Hours

Neurovascular Research

Date and Year	Title of Research Study	Number of Approved Hours

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

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

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.

NVRN RECERTIFICATION OPTION 2
Category 5 Hours

Scientific Neurovascular Publication

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

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):

- | | |
|---|---|
| <input type="checkbox"/> Neuro-Telemetry and/or Stroke Unit | <input type="checkbox"/> Mixed Critical care |
| <input type="checkbox"/> Neuro-ICU | <input type="checkbox"/> Emergency Department |

Highest Educational Degree (select only one):

- | | | | |
|--|--|---|------------------------------|
| <input type="checkbox"/> RN Diploma | <input type="checkbox"/> BSN or equivalent | <input type="checkbox"/> DNP | <input type="checkbox"/> PhD |
| <input type="checkbox"/> Associate Degree | <input type="checkbox"/> MS/MSN | <input type="checkbox"/> Other (please specify) _____ | |
| <input type="checkbox"/> Physician Assistant | | | |

Work Function (select all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Case manager | <input type="checkbox"/> Consultant | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Clinical Educator | <input type="checkbox"/> Academic Faculty | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Stroke Coordinator | |
| <input type="checkbox"/> Other (specify) _____ | | |

Primary Work Setting (select one):

- | | |
|---|---|
| <input type="checkbox"/> School of nursing | <input type="checkbox"/> University/teaching hospital |
| <input type="checkbox"/> Private physician practice | <input type="checkbox"/> Community hospital |
| <input type="checkbox"/> Outpatient clinic | <input type="checkbox"/> Rehabilitation facility |
| <input type="checkbox"/> Other (please specify) _____ | |

Years in neurovascular care:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> 2-5 year | <input type="checkbox"/> 11-15 years |
| <input type="checkbox"/> 6-10 years | <input type="checkbox"/> More than 15 years |

Reason you are seeking certification (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Professional recognition | <input type="checkbox"/> Personal recognition | <input type="checkbox"/> Job requirement |
| <input type="checkbox"/> Financial reward (such as bonus) | | |
| <input type="checkbox"/> Other (specify) _____ | | |

In what country did you do your training?

- | | |
|--|--|
| <input type="checkbox"/> United States | <input type="checkbox"/> Other (specify) _____ |
|--|--|