NVRN® 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: _____

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	
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 1,000 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_____
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 1,000 practice hours in neurovascular nursing over the past 5 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 *OR* Courses**	**Number of Approved Hours**

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

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):

_____ Neuro-Telemetry and/or Stroke Unit
_____ Neuro-ICU
_____ Mixed Critical care
_____ Emergency Department

Highest Educational Degree (select only one):

_____ RN Diploma
_____ Associate Degree
_____ Physician Assistant
_____ BSN or equivalent
_____ MS/MSN
_____ DNP
_____ PhD
_____ Other (please specify) _____

Work Function (select all that apply):

_____ Administrator
_____ Case manager
_____ Clinical Educator
_____ Physician Assistant
_____ Other (specify)_____
_____ Clinical Nurse Specialist
_____ Consultant
_____ Academic Faculty
_____ Stroke Coordinator
_____ Nurse Practitioner
_____ Researcher
_____ Staff Nurse

Primary Work Setting (select one):

_____ School of nursing
_____ Private physician practice
_____ Outpatient clinic
_____ Other (please specify) _____
_____University/teaching hospital
_____ Community hospital
_____ Rehabilitation facility

Years in neurovascular care:

_____ 2-5 year
_____ 6-10 years
_____ 11-15 years
_____ More than 15 years

Reason you are seeking certification (check all that apply)

_____ Professional recognition
_____ Financial reward (such as bonus)
_____ Other (specify)_____
_____ Personal recognition
_____ Job requirement

In what country did you do your training?

_____ United States
_____ Other (specify) _____