# FNP / AGNP INITIAL CERTIFICATION BY EXAMINATION PAPER APPLICATION

***Important Information:***

- *Applicants may apply online to take the national certification examination at www.aanpcert.org*
- *Application forms can be downloaded for candidates who are unable to complete the application process via the AANPCB web-based certification system*
- *A non-refundable Paper Application Processing Fee is automatically charged for all paper applications, regardless of delivery method (email, mail, and fax) to AANPCB*
- *Incomplete applications will result in processing delays*
- *There is no charge for receipt of documents or RN license faxed, emailed, or mailed*
- *Month & Day of Birth and last 4 numbers of Social Security Number are required to process all applications*
- *Name on this application MUST MATCH 2 FORMS OF LEGAL ID required for admittance to the Testing Center, must match legal name used for certification purposes, and is the name that will be printed on the certificate and wallet card issued*
- *Refer to the checklist at the end of this application prior to submitting your application*

For Office Use

## I am applying for the following examination:

- ☐ **Family Nurse Practitioner**
- ☐ **Adult-Gerontology Primary Care Nurse Practitioner**

***PLEASE PRINT NEATLY. Unique Identifiers are established for all applicants.*** *The month and day of your birth, and last four numbers of the applicant's Social Security Number are required to process all applications. Legal given name must match the identification used for verification and admittance to the testing center.*

| | | |
|---|---|---|
| Month & Day of Birth (mm/dd): | Last 4 of SSN: | |
| AANPCB Certification # (begins with A , F, or AG) if applicable: | | |
| AANP Membership # (if applicable): | | |
| Name- First: | Middle: | Last: |
| Previous Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: Home | Cell | Work |
| Email Address: | | |

## CURRENT RN LICENSURE

*(May be accessed from your SBON online verification system)*

| State | RN License Number | Date Of Expiration |
|---|---|---|
| | | |
| | | |

## PRIMARY CARE NURSE PRACTITIONER PROGRAM DESCRIPTION

| | | | |
|---|---|---|---|
| **Degree:** | ☐ **MSN** | ☐ **DNP** | ☐ **Post-Graduate** |
| **Specialty:** | ☐ **Family NP** | ☐ **Adult-Gerontology Primary Care NP** | |
| **Dual Program:** | ☐ **No** | ☐ **Yes** | **If Yes, specify:** |
| **Graduate Program:** | | | |
| **University:** | | | |
| **Program Address:** | | | |
| **Name of Program Director:** | | | |
| **Program Director's Contact Phone:** | | | |
| **Date Program was/ or will be completed:** | Month | Day | Year |
| **Date Degree was/ or will be conferred:** | Month | Day | Year |
| **Program is accredited by the following organization:** | ☐ CCNE | ☐ ACEN | |
| **If Post-Graduate candidate, please provide information on graduate degree & date awarded:** | | | |

## APRN PRIMARY CARE CORE COURSES

Important: *If the advanced physiology/pathophysiology, advanced pharmacology, and advanced health assessment coursework was completed prior to 1999 and is not listed as three (3) separate graduate level courses on the applicant's transcript, the applicant will need to provide a letter from the NP Program Director indicating completion or integration of these courses.*

| Didactic | Course Number | Number of Credit Hours | Year Taken |
|---|---|---|---|
| **Advanced Pathophysiology** | | | |
| **Advanced Pharmacology** | | | |
| **Advanced Health Assessment** | | | |
| **Primary Care Course** | | | |
| **Primary Care Course** | | | |
| **Primary Care Course** | | | |

## ***PRIMARY CARE CLINICAL SITE INFORMATION***

| | |
|---|---|
| **Total Number of Faculty-Supervised Clinical Clock Hours you had, or will have, upon completion of the NP Program (minimum 500):** | |

| |
|---|
| **Site Name** |
| **Address** |
| **City State Zip** |
| **Site Specialty** |
| **Preceptor's Name including Credentials** |

| |
|---|
| **Site Name** |
| **Address** |
| **City State Zip** |
| **Site Specialty** |
| **Preceptor's Name including Credentials** |

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|---|
| **Site Name** |
| **Address** |
| **City State Zip** |
| **Site Specialty** |
| **Preceptor's Name including Credentials** |

| |
|---|
| **Site Name** |
| **Address** |
| **City State Zip** |
| **Site Specialty** |
| **Preceptor's Name including Credentials** |

## ***ATTESTATION STATEMENT FOR CERTIFICATION EXAMINATION***

*I certify that all the information provided on all pages of this Certification Application are true and correct. I further understand that timely submission of all supporting or required documentation, including applicable fees, is necessary for processing my application and failure to respond to a request for further information may result in a delay in taking the National Certification Examination. I acknowledge that I have accessed the* ***AANPCB Candidate Handbook*** *online at* www.aanpcert.org *and accept all policies as outlined in the Handbook. I also understand that all information I provide will be kept confidential and shall not be used for other purposes without my permission.*

**Signature:** _____ **Date:** _____

# STATE BOARD OF NURSING NOTIFICATION FORM

1. **AANPCB does not charge a verification fee to send status results to State Boards of Nursing.**
2. **Download this form and save to your computer, then enter and re-save your information before returning to AANPCB**
3. **Return completed SBON Notification Forms to AANPCB via fax, mail, or email. Please print clearly.**
4. **State Boards of Nursing may request notification of Certification, Failure, or Expiration Status.**

## APPLICANTS APPLYING FOR INITIAL CERTIFICATION

☐ Notify the following SBON that ***I am Eligible-To-Sit*** for the following AANPCB examination.
☐ **Adult-Gero Primary Care NP Exam** ☐ **Emergency NP Exam** ☐ **Family NP Exam**

☐ Notify the following SBON that ***I have taken the AANPCB Certification Examination*** as soon as my Certification status is released.
☐ **Adult-Gero Primary Care NP Exam** ☐ **Emergency NP Exam** ☐ **Family NP Exam**

## NURSE PRACTITIONERS CURRENTLY CERTIFIED BY AANPCB

☐ Notify the following State Board of Nursing of the ***Status of my current AANPCB National Certification***.
☐ **Adult NP** ☐ **Adult-Gero Primary Care NP** ☐ **Emergency NP** ☐ **Family NP** ☐ **Gerontologic NP**

☐ Notify the following State Board of Nursing of the ***Renewal of my AANPCB National Certification***.
☐ **Adult NP** ☐ **Adult-Gero Primary Care NP** ☐ **Emergency NP** ☐ **Family NP** ☐ **Gerontologic NP**

**My AANPCB Certification Number is** (begins with **A, AG, E, F,** or **G**): _____

## STATE BOARD OF NURSING (SBON) INFORMATION

Name of SBON: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Note: _____

## CANDIDATE/CERTIFICANT INFORMATION

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last 4 of SSN: _____ MM/DD of Birth (e.g.; 01/23): _____

Signature: _____ Date: _____


Main: (512) 637-0500
Fax: (512) 637-0540
www.aanpcert.org
certification@aanpcert.org
Toll-free: (855) 822-6727
PO Box 12926, Austin, TX 78711-2926

## *CERTIFICATION EXAMINATION FEE**

| | | |
|---|---|---|
| ☐ | ***AANP Members*** | **$290.00** |
| ☐ | ***Non-AANP Members*** | **$365.00** |

***TOTAL:*** $

**Fee includes a nonrefundable administrative paper application fee. Fees are subject to change without notice.*

☐ Enclosed is my check payable to: *American Academy of Nurse Practitioners Certification Board (AANPCB)*

Check #:_____ Money Order #:_____

Charge my credit card: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Name on Credit Card (Please print): _____

Card #_____ Expiration Date: _____

Signature: _____

☐ Check here if you would like to receive information from the American Association of Nurse Practitioners (AANP) Membership Organization including, but not limited to, CE opportunities, health care policy information, National Conference information, and additional beneficial information for Nurse Practitioners.

## *APPLICATION CHECKLIST*

- ☐ Application form is completely filled out, signed & dated
- ☐ Name on application **MUST MATCH 2 FORMS OF LEGAL ID** required for admittance to the Testing Center
- ☐ Name on application matches legal name used for certification purposes
- ☐ Program Description and Primary Care course information filled out completely
- ☐ Transcript shows evidence of the 3 Ps (advanced pathophysiology, advanced pharmacology, and advanced health assessment) as 3 separate courses. If not, a letter from the NP program director has been requested.
- ☐ Clinical clock hours filled in (must be equal to or greater than 500 clinical clock hours)
- ☐ Practice site and preceptor information filled out completely
- ☐ Copy of current RN license includes expiration date
- ☐ ***State Board of Nursing Form*** is completed and attached if required
- ☐ ***Official Final Transcript(s)/Post-Graduate Certificate*** **requested**
- ☐ Fee payment attached (check) or credit card information completed
- ☐ Update and maintain ***Online Profile*** for status updates and communication regarding this application and for further correspondence from the certification program
- ☐ **Keep a photocopy of completed application for your records**

***Fax or email completed paper applications, RN licenses, and correspondence to:*** (512) 637-0540 Certification@aanpcert.org

***Certification Administration phone numbers:*** Main: (512) 637-0500 Toll: (855) 822-6727

***Applications and RN licenses may be mailed to AANPCB at:*** Capitol Station, LBJ Building PO Box 12926 Austin, TX 78711-2926

***For overnight delivery to AANPCB:*** 2600 Via Fortuna, Suite 240 Austin, TX 78746