# Application for Advanced Certification in HIV/AIDS Nursing (AACRN)

**Candidate Information.** Please print clearly.

First Name_____Middle Initial _____

Last Name_____Suffix _____

Preferred Pronouns_____

Address _____

City_____State_____Postal Code_____Country _____

Email Address _____

Primary Phone _____Alternate Phone _____

Current RN License Number_____License State_____Expiration Date _____

**Eligibility and Background Information.** Choose only one answer for each question unless otherwise directed.

**A. Percent of Working Time Currently Spent in HIV/AIDS Nursing:**

○ Less than 25% ○ 25-50% ○ 51-75% ○ More than 75%

**B. Primary Position:**

○ Case Manager/Coordinator
○ Consultant
○ Infection Control Practitioner
○ Nurse Researcher
○ Staff Nurse/Clinician
○ Clinical Nurse Specialist
○ Director/Assistant Director
○ Nurse Educator/Faculty Member
○ Patient Educator
○ Other _____
○ Counselor
○ Head Nurse/Manager
○ Nurse Practitioner
○ Sales/Marketing Industry Nursing Representative

**C. Area of Professional HIV/AIDS Emphasis:**

○ Adult ○ Pediatrics ○ Both Adult and Pediatrics

**D. Primary Practice Setting:**

○ Clinical Trial Group
○ Forensic Setting (jail, prison)
○ Hospice
○ Inpatient: Teaching Hospital
○ Outpatient/Ambulatory
○ Public/Community Health
○ Other _
○ Community-Based Organization
○ HIV Testing Center
○ Inpatient: Community Hospital
○ Inpatient: University Affiliated Hospital
○ Primary Prevention Program
○ School of Nursing
○ Family Planning/STD
○ Home Care
○ Inpatient: Non-teaching Hospital
○ Long-term Care Facility
○ Private/Group Practice/Physician's Office
○ Substance Abuse Treatment Center

**E. Experience in HIV/AIDS Nursing:**

○ 2000 Hours ○ Less than 2 years ○ 2 years ○ 3-6 years ○ 7-10 years ○ 10+ years

**F. Employment Status:**

○ Full-Time ○ Part-Time ○ Retired ○ Unemployed

**G. Primary Practice Location:**

○ Mixed ○ Rural ○ Suburban
○ Urban (less than 1 million population) ○ Urban (more than 1 million population) ○ Not applicable

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**H. Highest Academic Level:**

- ○ Doctor of Nursing Practice (DNP)
- ○ Doctor of Nursing Science (DSNC or SDN)
- ○ Doctor of Philosophy in Nursing (PhD)
- ○ Master of Arts in Nursing (MA)
- ○ Master of Public Health (MPH)
- ○ Master of Nursing (MN)
- ○ Master of Science in Nursing (MSN)
- ○ Master of Science with Nursing concentration (MS)
- ○ Nursing Doctor (ND)
- ○ Other

**I. Other certifications held:** (Choose all that apply)

- ○ AOCN
- ○ BC
- ○ CCNS
- ○ CEN
- ○ Hospice
- ○ None
- ○ Other

**J. Are you currently a member of ANAC/CANAC?** ○ No ○ Yes *If yes, indicate Membership Number* _____

**K. Do you/will you receive a monetary reward for certification?** ○ No ○ Yes

**L. Is certification part of the job/performance/clinical ladder rating criteria?** ○ No ○ Yes

**M. Are you currently or have you ever been certified in Advanced HIV/AIDS Nursing (AACRN)?**
○ No ○ Yes *If yes, please supply expiration date*_____

**N. Are you currently, or have you ever been, certified as an HIV/AIDS Registered Nurse (ACRN)?**
○ No ○ Yes *If yes, please supply expiration date*_____

**O. Where Did You Hear About the Certification in HIV/AIDS Nursing Program?** (Choose all that apply)

- ○ ANAC Annual Conference
- ○ ANAC Chapter
- ○ ANAC Mailing
- ○ Colleagues
- ○ JANAC
- ○ Other Journal
- ○ Other _____

**Optional Information**

**Race**
○ African American ○ Asian ○ Hispanic ○ Native American ○ White ○ Other

**Age Range**
○ Under 25 ○ 25-29 ○ 30-39 ○ 40-49 ○ 50-59 ○ 60+

**Gender**
○ Male ○ Female ○ Transgender ○ Non-binary ○ Prefer not to answer

**Candidate Signature**

I have read and understand the requirements for candidate eligibility. I affirm that all statements given on this application are true and correct to the best of my knowledge and that the HANCB is hereby authorized to contact any organization or individual listed hereon to verify my education and licensure history.

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

**Payment Options**

Certification Fee, ANAC/CANAC Member: $350

Certification Fee, Non-ANAC/CANAC Member: $450

Payment can be made online via the HANCB website.

Note you do not need to have a PayPal account – you can check out as a guest.

Alternatively, HANCB now utilizes the secured third-party platform BILL.com for invoicing and collecting payments.

You can be invoiced for your certification fee by providing the following information:

**Name** _____

**Address** _____

**Phone Number** _____

**Email address for invoice** _____

**Application for Advanced Certification in HIV/AIDS Nursing (AACRN): Supervisor/Colleague Verification**

**Please print clearly.**

Candidate Name: _____

Job Title: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Postal Code: _____ Country: _____

Supervisor/Colleague Name: _____

Job Title: _____

Email Address: _____

Primary Phone: _____ Alternate Phone: _____

Give brief details of the above candidate's job role and experience:

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By my signature below, I verify that the above-named candidate for the Specialty Certification in Advanced HIV/AIDS Nursing Practice has a minimum of 2,000 hours of HIV/AIDS nursing experience within the five years prior to application.

Name: _____

Signature: _____

Date: _____

**Email completed form to hancb@anacnet.org**