



Application for Certification in HIV/AIDS Nursing (ACRN)

Candidate Information. Please print clearly.

First Name _____ Middle Initial _____

Last Name _____

Suffix _____ Preferred Pronouns _____

Address _____

City _____ State _____ Postal Code _____ Country _____

Email Address _____

Day Phone _____ Other 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:

- | | | |
|---|---|--|
| <input type="radio"/> Clinical Nurse Specialist | <input type="radio"/> Consultant | <input type="radio"/> Counselor |
| <input type="radio"/> Director/Assistant Director | <input type="radio"/> Head Nurse/Manager | <input type="radio"/> Infection Control Practitioner |
| <input type="radio"/> Nurse Educator/Faculty Member | <input type="radio"/> Nurse Practitioner | <input type="radio"/> Nurse Researcher |
| <input type="radio"/> Patient Educator | <input type="radio"/> Sales/Marketing Industry Nursing Representative | |
| <input type="radio"/> Staff Nurse/Clinician | <input type="radio"/> Other | |

C. Area of Professional HIV/AIDS Emphasis:

- Adult Pediatrics Both Adult and Pediatrics

D. Primary Practice Setting:

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

E. Experience in HIV/AIDS Nursing:

- Less than 2 years 2 years 3-6 years 7-10 years More than 10 years

F. Employment Status:

- Full-Time Part-Time Retired Unemployed

G. Primary Practice Location:

- | | | |
|-----------------------------|--------------------------------------|--|
| <input type="radio"/> Rural | <input type="radio"/> Suburban | <input type="radio"/> Urban (less than 1 million population) |
| <input type="radio"/> Mixed | <input type="radio"/> Not applicable | <input type="radio"/> Urban (more than 1 million population) |



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H. Highest Academic Level:

- Associate Degree, Nursing
- Baccalaureate, Other
- Doctorate in Nursing
- Master's Degree, Other
- Associate Degree, Other
- Diploma in Nursing
- Doctorate, Other
- Other _
- Baccalaureate, Nursing
- Diploma/Certificate, Other
- Master's in Nursing

I. Other Certifications Held: (Choose all that apply)

- CCRN
- RN, C
- CEN
- RN, CS
- CIC
- None
- CRNH
- Other ____
- OCN

J. Where did you hear about the Certification in HIV/AIDS Nursing Program? (Choose all that apply)

- ANAC Annual Conference
- Colleagues
- Other _
- ANAC Chapter
- JANAC
- ANAC Mailing
- Other Journal

K. Are you currently a member of ANAC/CANAC?

- No
- Yes *If yes, please indicate Membership Number _____*

L. Are you currently or have you been certified in HIV/AIDS Nursing?

- No
- Yes *If yes, please supply certification expiration date _____*

Optional Information

- Race** African American Asian Hispanic White Native American 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:** _____



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Payment Options

Certification Fee, ANAC/CANAC Member: \$250

Certification Fee, Non-ANAC/CANAC Member: \$350

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 Certification in HIV/AIDS Nursing (ACRN):
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:

By my signature below, I verify that the above-named candidate for the Specialty Certification in HIV/AIDS Nursing Practice has a minimum of 2 years of HIV/AIDS nursing experience.

Name: _____

Signature: _____

Date: _____

Email completed form to hancb@anacnet.org