ANCC PROUDLY OFFERS CERTIFICATION FOR

Family Nurse Practitioner

Credential: FNP-BC

Eligibility Criteria

- Hold a current, active RN license in a state or territory of the United States or hold the professional, legally recognized equivalent in another country
- Hold a master's, postgraduate, or doctoral degree from a family nurse practitioner program accredited by the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC). A minimum of 500 faculty-supervised clinical hours must be included in your family nurse practitioner program.
- Three separate, comprehensive graduate-level courses in:
  - Advanced physiology/pathophysiology, including general principles that apply across the life span
  - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts, and approaches
  - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents
- Content in:
  - Health promotion and/or maintenance
  - Differential diagnosis and disease management, including the use and prescription of pharmacologic and nonpharmacologic interventions

Family Nurse Practitioner

KEEP FOR YOUR RECORDS

TEST CONTENT OUTLINE

This free study aid will show you the subject areas that are covered on the exam.
Download at **www.nursecredentialing.org**.

2013 APPLICATION FEES

Prices below include a $140 nonrefundable administrative fee.

ANA Member	$270	Required attachment: A copy of your American Nurses Association membership card (Full and Direct ANA Individual members only. Individual Affiliate members excluded from this offer.)
Discount	$340	For members of American Association of Nurse Practitioners (You will need your membership ID number and expiration date to use this rate.)
Student Discount	$290	For student members of American Association of Nurse Practitioners (You will need your membership ID number and expiration date to use this rate.)
Nonmember	$395	

Additional Special Fees:

International Testing	$125	See **www.nursecredentialing.org** for details.

PREPARING FOR THE EXAM

This exam is a computer-based test. This means you can apply all year and test during a 90-day window at a time and location convenient to you. Applications for this certification will be accepted at any time.

Detailed information about the application and testing process, withdrawing an application, ineligibility to test, and other frequently asked questions is in the General Testing and Renewal Handbook available at **www.nursecredentialing.org**.

If you are paying by credit card, please go to your certification specialty page at **www.nursecredentialing.org** and click on the button that says "Apply Online." Using the online system with your MasterCard or Visa will save you time. If you are paying by check, you will need to use this form. Please, type into, save, and print this application. Please sign the form, attach required documents, staple the entire application together (including the check), and mail the complete application. ANCC will review it to determine whether your application meets eligibility criteria.

Information to prepare for the exam, such as review courses, detailed test content outline, references, and sample questions, is available at **www.nursecredentialing.org**. Or call our Customer Care Center at 1.800.284.2378.

If you require a verification of exam eligibility and/or certification, visit **www.nursecredentialing.org** or call 1.800.284.2378.

MAILING INSTRUCTIONS

Print legibly using either black or blue ink. **Keep a photocopy of your application for your records.** Submit an application, a copy of your RN license, and payment. If your state does not issue a paper license, you should include a printout from your state board of nursing's online verification system. Your program director must also submit the Validation of Advanced Practice Nursing Education Form by email or mail. Remember to attach all required supporting documents and mail to:

American Nurses Credentialing Center
P.O. Box 8785
Silver Spring, MD 20907-8785

ANCC is the only nurse credentialing organization to successfully achieve ISO 9001:2008 certification in the design, development, and delivery of global credentialing services and support products for nurses and healthcare organizations.

To-Do List

KEEP FOR YOUR RECORDS

Date completed:

_____ Read this entire application, front to back.

_____ Determine whether you are/when you will be eligible to take the exam.

_____ Complete any missing requirements such as practice hours or continuing education hours.

_____ Download the full-length Test Content Outline and Reference Lis for this exam at the ANCC website: **www.nursecredentialing.org**. These documents are used to create the exam.

_____ Download and read the General Testing and Renewal Handbook from **www.nursecredentialing.org** for a comprehensive listing of policies and critical certification candidate information.

_____ STUDY PLAN

Approximately 6 months before you plan to take your exam, develop a study plan. This could include self-study, finding a study buddy or group, taking a review course, taking an online narrated course, reviewing current textbooks and articles, or other methods. The key is to have a study plan and follow through with it. For ANCC exam preparation resources, refer to the back cover of this brochure.

_____ Review the sample test questions on the ANCC website at **www.nursecredentialing.org**.

_____ FILL OUT THE APPLICATION

Two to 3 months before you plan to take the exam, fill out the application, attaching all required documents.
Required attachments (please mail everything together in one envelope):

Photocopy of RN license (if your board of nursing issues a paper license)
Official transcript(s) in a sealed envelope (transcripts may be mailed separately by the university directly to the P.O. Box below)
Photocopy of membership card (if you are claiming a discount)
Validation of Advanced Practice Nursing Education Form
Payment (if you are paying by check)

Attachments for special accommodations:
Those requesting special accommodations under the Americans with Disabilities Act (ADA) must submit a physician's letter that addresses specific required information. Please go to **www.nursecredentialing.org** or call 1.800.284.2378 for full instructions.

_____ MAIL APPLICATION

Mail your application and attachments to:
American Nurses Credentialing Center
P.O. Box 8785 • Silver Spring, MD 20907-8785

Within 2 weeks from the date you mailed your application, you will receive a Receipt of Application Notice in the mail. If you do not, call 1.800.284.2378.

Within 6 weeks from the date you mailed your application, you will receive either an Authorization to Test Notice or a letter requesting additional information. Your Authorization to Test Notice will give you 90 days during which to schedule and take your exam. Read it carefully and follow the directions.

_____ RESULTS

After you have taken your exam, you will receive results instantly at the test site. If you passed, you will receive a certificate and pin within two months. Certifications are good for 5 years.

_____ Request your one free verification of certification at **www.nursecredentialing.org**. Additional verifications of certification can also be ordered from this site. ANCC does not automatically send verification to your state board of nursing or employer. Please request the verifications you need.

_____ After you pass the exam, download the Certification Renewal materials from the ANCC website at **www.nursecredentialing.org** and begin planning for your certification renewal.

ANCC CERTIFICATION APPLICATION FORM

Family Nurse Practitioner

Staff use only: ☐ E ☐ P ☐ NE

GENERAL INFORMATION

Use your legal name on the application. This name must match photo identification used for examination entry and will be the name printed on your certificate.

Last Name | First Name | MI

Maiden or Other Past Legal Names | Social Security Number

Home Address

City | State | Zip/Postal Code | Country

Home Phone | Home Fax | Personal Email

Employer Name

Employer Address

City | State | Zip/Postal Code | Country

Work Phone | Work Fax | Work Email

TYPE OF PRIMARY POSITION

☐ Nurse Manager
☐ Nurse Practitioner
☐ Administrator/DON/CNO/VP Nursing
☐ Associate/Assistant Administrator
☐ Educator
☐ Researcher
☐ Clinical/Staff Nurse
☐ Clinical Nurse Specialist
☐ Consultant
☐ Other: _____

2013 APPLICATION FEES

Prices below include a $140 nonrefundable administrative fee.

☐ $270 ANA Member ☐ $340 Discount ☐ $290 Student ☐ $395 Nonmember ☐ $125 International Testing

☐ Personal Check/Money Order (payable to ANCC)
☐ Charge Card (MasterCard or VISA only)
☐ Check here if this is an ATM/Debit card. See authorization below.*

Amount Enclosed: _____
Amount to Be Charged: _____
Promotional Code (if applicable): _____

Account Number | Exp. Date

Print Name on Card | Signature

**ATM/Debit card users only:* I understand and agree that, by using an ATM/Debit card, I am authorizing ANCC to debit my account for the amount specified above. Further, I understand and agree that if the ATM/Debit transaction fails or is declined, I am authorizing ANCC to complete the transaction as a credit card charge, if possible.

SPECIAL ACCOMMODATIONS/AMERICANS WITH DISABILITIES

☐ Check here if you have a disability as defined by the Americans with Disabilities Act (ADA) and require a special accommodation. Please call 1.800.284.2378 for instructions or visit **www.nursecredentialing.org/ADA.aspx**.

ANCC VALIDATION OF ADVANCED PRACTICE NURSING EDUCATION FORM

Please download the ANCC Validation of Advanced Practice Nursing Education Form from **www.nursecredentialing.org/APRN-Validation-Form**, fill in section 1, and give the form to the Program Director of the program from which you graduated. You may send it to them by email and they may submit the completed form to ANCC by email or mail. This form may be completed after you have submitted your certification application.

EDUCATION

Check all that apply:

- ☐ Diploma
- ☐ Associate Degree in Nursing
- ☐ Associate Degree in Other Field
- ☐ Baccalaureate in Nursing
- ☐ Baccalaureate in Other Field
- ☐ Master's in Nursing
- ☐ Master's in Other Field
- ☐ PhD in Nursing
- ☐ PhD in Other Field
- ☐ EdD
- ☐ DNP
- ☐ DNSc
- ☐ ND
- ☐ Other: _____

Please list all degrees you have been awarded with the most recent degree first (do not include high school). Attach additional page if necessary.

Required attachment: All official degree transcripts. The following are not accepted: photocopies, faxes, attached transcripts that are not in a sealed envelope from the school. International degrees require validation by a company such as CGFNS or WES.

School Name

Major/Area of Study | Date and Degree Conferred

School Name

Major/Area of Study | Date and Degree Conferred

☐ I have requested my school send transcripts directly to ANCC.
☐ I have obtained transcripts in a sealed envelope directly from my school and have attached these transcripts to this application.

LICENSURE INFORMATION All candidates must complete this section in its entirety

Required attachment: Attach a copy of your license. If your state does not issue a paper license, you should include a printout from your state board of nursing's online verification system.

☐ Check this box if your RN license is not from a state or territory of the United States.

Current RN License Number

State/Country | Expiration Date (month/date/year)

STATEMENT OF UNDERSTANDING

I hereby apply for certification offered by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for certification. I understand that I am subject to all eligibility requirements for certification as described in this application and that eligibility for certification depends on successfully completing specified certification program requirements. If certified, my name will be included in the official listing of certified nurses.

By signing below, I authorize ANCC staff and the Commission on Certification to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to verify my credentials, education preparation, practice, professional standing, and any other information included in, submitted with, or necessary for review of this application.

I expressly acknowledge and agree that information accumulated by ANCC through the certification process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to schools or external researchers. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without my permission.

I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature, that I will maintain an active registered nurse license throughout the entire certification period, including all renewal periods. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for certification shall be sufficient cause for ANCC to: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; withhold this or other ANCC certifications; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

I further understand that if my certification record is audited, I will be required to submit documentation to support the information on my application. I further understand that if I fail to timely submit supporting documentation, ANCC can: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

(Applications received without a signature incur a delay in processing, which will cause a delay in the review of your application and ability to take a certification examination.)

Required Signature | Print Name | Date

MAILING LIST REFUSAL

ANCC may release mailing lists from its certification database to organizations or individuals who have information to distribute that would be beneficial to nurses or to nursing and credentialing research. If you do not wish your name and mailing address to be released for marketing purposes, please mark the decline option below.

☐ I do not wish my name and mailing address to be released for any marketing purposes.

DEMOGRAPHIC AND EMPLOYMENT INFORMATION

1. Location of facility:
- ☐ Urban
- ☐ Rural
- ☐ Suburban
- ☐ Outside the U.S.

2. Average number of patient encounters/visits per year at your primary place of employment:
- ☐ ≤ 1,000
- ☐ 1,001–5,000
- ☐ 5,001–10,000
- ☐ 10,001–20,000
- ☐ 20,001–40,000
- ☐ 40,001–60,000
- ☐ 60,001–80,000
- ☐ 80,001–100,000
- ☐ > 100,000

3. Will you receive a monetary reward/ compensation from your employer for certification?
☐ Yes ☐ No

If yes:
$ _____ per hour
$ _____ per year
$ _____ one time

4. Number of individuals you supervise:
_____

5. Years of experience as an RN (round to nearest whole year):_____

6. Total years of experience in the field in which certification is desired (round to nearest whole year):
_____

7. Primary place of employment (check one):
- ☐ Ambulatory care
- ☐ Physician-managed group practice
- ☐ Home health
- ☐ Hospice
- ☐ Hospital
- ☐ Managed care
- ☐ Nurse-managed group practice
- ☐ Nursing home
- ☐ Long-term care
- ☐ Occupational health/ environmental health
- ☐ Office nursing
- ☐ Public health/community health
- ☐ School health
- ☐ School of nursing/ university/college
- ☐ Federal/military
- ☐ Other:

_____

8. Patient population/ conditions representative of your practice (check all that apply):
- ☐ Medical-Surgical
- ☐ Cardiac
- ☐ Endocrine/Diabetes
- ☐ Pulmonary
- ☐ Neurology
- ☐ Renal/Urology
- ☐ Orthopedics
- ☐ Rehabilitation
- ☐ Gerontology
- ☐ Long-Term Care
- ☐ Perinatal
- ☐ Postpartum
- ☐ Labor and Delivery
- ☐ Pediatrics
- ☐ ER
- ☐ Trauma
- ☐ Critical Care
- ☐ Psychiatric
- ☐ Other:

_____

9. Age range of your primary patient population:
- ☐ Birth–1
- ☐ 2–21
- ☐ 22–65
- ☐ 66+

10. Average number of hours worked per week:
- ☐ 8 or fewer
- ☐ 9–16
- ☐ 17–24
- ☐ 25–32
- ☐ 33–40
- ☐ > 40

11. Size of facility (total number of beds):
- ☐ N/A
- ☐ 1–100
- ☐ 101–250
- ☐ 251–500
- ☐ > 500

12. Is certification part of your employer's job performance/clinical ladder rating criteria?
☐ Yes ☐ No

13. How did you obtain this application?
- ☐ From ANCC website
- ☐ Mailed from ANCC
- ☐ From my school
- ☐ From my workplace
- ☐ At a trade show
- ☐ Other:

_____

14. Please check the professional organizations of which you are a member (check all that apply):

- ☐ AAACN American Academy of Ambulatory Care Nursing
- ☐ AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
- ☐ AANP American Association of Nurse Practitioners
- ☐ ANA American Nurses Association
- ☐ ANPD Association for Nursing Professional Development
- ☐ APHA American Public Health Association (Public Health Nursing Section)
- ☐ APNA American Psychiatric Nurses Association
- ☐ ASPMN American Society for Pain Management Nursing
- ☐ GAPNA Gerontological Advanced Practice Nurses Association
- ☐ ISPN International Society of Psychiatric-Mental Health Nurses
- ☐ NACNS National Association of Clinical Nurse Specialists
- ☐ NGNA National Gerontological Nursing Association
- ☐ PCNA Preventive Cardiovascular Nurses Association
- ☐ SVN Society for Vascular Nursing
- ☐ Other: _____

OTHER DEMOGRAPHIC INFORMATION

Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Sex: ☐ M ☐ F

Date of Birth: _____ (month/date/year)

Race/Ethnic Group
- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Other:

_____