CCARRN Certified Addictions Registered Nurse Examination Application Ducudes Pages 10 - 15 NSTRUCTIONS Somplete ALL sections of this application. Documents and payment must be mailed together to: ANCB Examination Processing, C/O C-NET, 35 Journal Square, Suite 901 Jersey City, NJ 07306			All items must Signed Applicat Data Form Verification Form Verification of 3 Copy of RN Lice A Copy of your Be advised:	Deplication Checklist: t be returned together with certific ion Form m (2000 hours of related prace 0 Contact Hours in addiction ense showing expiration date current government issued p incomplete applications	ttice) nursing hoto ID
SECTION 1:	CANDIDATE INFORMATION		To avoid additional fees	you must complete <u>ALL</u> space	es in this section
Be advised: We will enter your name as it appears on your supplied government issued photo ID. The line below is for application processing only.					
NAME MAILING	Current Legal Last Name	Maider	n Legal Fir	st Name	Middle Name
ADDRESS	Street	Apt#	City	State	Zip
LAST 4 DIGITS OF SOCIAL SECURITY NUMBER			E-MAIL Your exam	permit will be emailed to this	email address
CELL/ HOME F	PHONE NUMBER		WORK NUMBE	R	
SECTION 2: RN LICENSE			To avoid additional fees	you must complete ALL space	es in this section
STATE: PERM		MANENT NUMBER: _			
DATE OF ORIGINAL LICENSE:		_ EXPII	RATION DATE:		
SECTION 3: APPLICANT SIGNATURE			To avoid additional fee	s you must complete ALL spac	es in this section

### APPLICANT: PLEASE READ AND SIGN THE STATEMENT OF UNDERSTANDING BELOW:

**Denial, Suspension, or Revocation of Certification**. The occurrence of any of the following actions will result in the denial, suspension, or revocation of Addictions Nursing Certification: (1) falsification of the CARN application; (2) falsification of any material information requested by the ANCB; (3) any restrictions such as revocation, suspension, probation, or other sanctions of professional RN license by nursing authority; (4) misrepresentation of CARN status; (5) cheating on the CARN examination.

### STATEMENT OF UNDERSTANDING

I hereby attest that I have read and understand the Addictions Nursing Certification Board's policy of Denial, Suspension, or revocation of Certification and that its terms shall be binding on all applicants for certification and all certified addictions nurses for the duration of their certification. I hereby apply for certification offered by the Addictions Nursing Certification Board (ANCB). I understand that certification depends upon successful completion of the specified requirements. I further understand that the information accrued in the certification process may be used for statistical purposes and for evaluation of the certification program. I further understand that the information from my certification records shall be held in confidence and shall not be used for any other purpose without my permission. To the best of my knowledge, the information contained in this application is true, complete, correct, and is made in good faith. I understand that the ANCB reserves the right to verify any or all information on this application.

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Legal Signature

### **SECTION 4: ADDITIONAL INFORMATION**

### **INCOMPLETE STATUS**

To be considered "complete," an application must be submitted without missing documentation or requested information (this includes the correct payment). Incomplete applications are subject to a non-refundable incomplete application fee. To avoid additional charges, be sure to submit all items on the checklist (top of page 12) together with the application and check the application for all applicable signatures, dates, and information before submitting it to C-NET.

### CONTACT HOUR CERTIFICATES

You are required to list all forty-five (30) contact hours of continuing education on the verification form supplied in <u>this</u> application. To reduce paper, please do not submit contact hour certificates. You should, however, be able to produce all contact hour certificates upon request, as random audits are routinely performed for compliance purposes.

### APPLICATION PROCESSING TIME

Standard processing time for CARN applications is four weeks from the time C-NET receives the application. If your application submission is incomplete, C-NET will notify you of your incomplete status by mail. C-NET is not responsible for US Postal Service delays. Additionally, if the applicant has not received any communication from C-NET within four weeks of the application postmark date, the applicant is responsible for informing C-NET immediately at info@cnetnurse.com.

### **EXAMINATION PERMITS**

Examination permits will be emailed only to qualifying candidates. The permit will carry a 90-day testing window. You may schedule a test anytime during the 90-day window, but scheduling options may decrease the longer you wait to book your exam. C-NET does not handle computer-based exam scheduling by phone. All scheduling will be handled by you directly through the provided online link.

STANDARD EXAM FEE \$300.00	Enclosed: Mone	ey Order/ Check Credit Card (Complete below	
When paying by credit card, you have the	APPLICANT NAME		
option to email your application directly to info@cnetnurse.com for faster processing	CARD HOLDER NAME (If different than above)		
	Visa or Master Card Only:		
	CARD NUMBER		
	Exp Date	Phone Number	
AUTHORIZATION		DATE:	

**CLANCE INVIE:** Your signature on this form acknowledges and authorizes the Center for Nursing Education and Testing (C-NET) to charge your credit card for a total of the amount indicated. Written refund requests shall be accepted by C-NET either: a) up to four (4) weeks after the application postmark date (or date received), or b) before the date the examination permit is issued (whichever comes first). The written request must be submitted by the purchaser and must include the applicant's full name, the last four digits of the social security number, and the name of the exam being canceled or the request will not be considered. All refunds are issued minus the application processing fee and any other non-refundable fees indicated in the application brochure or websites (cnetnurse.com). Refund requests received after the deadline will not be considered, and any fund received after the deadline shall become non-refundable and non-transferable.

Addictions Nursing Certification Board (ANCB)

### **SECTION 6: ANCB DATA FORM**

To avoid addition fees, complete and return this form

Please complete the following items to provide important research data to the Additions Nursing Certification Board. The information will be handled anonymously and will be used only for research to assist in the assessment to test validity.

### ----- DATA FORM ------

### Check your current position:

- □ Administrator
- Nurse Manager
- □ Supervisor
- □ Clinical Nurse Specialist
- □ Researcher
- □ Educator
- □ Staff Nurse
- □ Nurse Practitioner (NP)
- □ Other

### Gender:

- Male
- □ Female
- □ Other
- □ Prefer not to answer

### **Ethnic Group:**

- American Indian or Alaska Native
- □ Asian (Indian
- Subcontinent)
- Other Asia (Far East, South East Asia)
- □ Black or African American
- □ Native Hawaiian or Other
- Pacific Islander
- Hispanic/Latino
- □ White
- □ Other
- □ Prefer not to answer

#### Years of RN experience:

- □ 0-5 years
- □ 6-10 years
- □ 11-15 years
- □ 16-20 years
- □ 21-25 years
- □ 26-30 years
- □ 31-35 years
- □ 36-40 years
- □ 41-45 years
- □ 46-50 years

Addictions Nursing Certification Board (ANCB)

 $\Box$  51+ years

# Years of RN experience in addictions nursing:

- □ 0-5 years
- $\Box$  6-10 years
- $\Box$  11-15 years
- □ 16-20 years
- □ 21-25 years
- □ 26-30 years
- □ 31-35 years
- □ 36-40 years
- □ 41-45 years
- □ 46-50 years
- $\Box$  51+ years

### Highest Level of Education:

- Diploma in Nursing
- □ Associate's in Nursing
- Associate's Other
- Bachelor's in Nursing
- □ Bachelor's Other
- □ Master's in Nursing
- □ Master's Other
- Doctorate in Nursing
- Doctorate Other

#### **Current Practice Setting:**

- General Hospital
- Addictions Specialty Hospital/Unit
- □ Educational Institution
- □ Private Practice
- □ Free-Standing Facility
- Detoxification Unit
- Medication Management with Partial Agonist, Full Agonist and/or Antagonist Treatment
- □ Community Agency
- □ Other
- □ Currently Unemployed

## Currently certified in any other specialty:

12

- □ Yes

### Years in your current position?

- □ Less than one year
- □ 1-3 Years
- □ 4-6 Years
- □ 7-10 Years
- □ More than 10 year

### What shifts do you usually work?

- Days
- □ Evenings
- □ Nights
- □ Weekends

# Primary client problems you see (at least 25% of working hours):

- □ Substance Use
  - Treatment/Alcohol and Drug
- Dual Diagnosis
- □ Infectious Diseases
- □ Eating Disorders
- Gambling Disorder
- General Disorder
- □ Sexual Disorder

□ Infants/Children

 $\Box$  Adults (age 21-64)

□ Newborns

□ Other

□ Nursing Journal

□ IntNSA Newsletter

certification?

□ Marketing

□ Codependency/Family

Age group you mostly work with:

□ Adolescents (age 12-20)

Current professional membership?

Addictions (IntNSA)

How did you hear about this

□ State Nurses Association

Colleague Marketing Employer

National League for Nursing

□ Sigma Theta Tau International

IntNSA Website

Other Website

Other

**REVISED 3/2023** 

□ Older Adults (age 65 and up)

□ International Nurses Society on

### SECTION 7: VERIFICATION OF EXPERIENCE

PHOTOCOPY THIS PAGE if submitting more than one verification

This form is part of the application process for the Certified Addictions Registered Nurse (CARN) Certification Exam. Applicants are required to provide evidence of having a **minimum of 2000 hours (1 year)** of nursing experience related to addictions. As supervisor of the applicant submitting this form, please verify the number of experience hours they have accumulated (pertaining to addiction nursing) at your facility within the **last three (3) years**. IMPORTANT: In order for this application to be processed, you must complete <u>all sections</u> below before returning this form to the applicant.

### ----- VERIFICATION FORM FOR: CARN ------

All sections below must be completed by supervisor

PART 1 APPLICANT NAME I AM COMPLETEING THIS VERIFICATION FOR:	PART 4 SUPERVISOR INFORMATION
Print first and last name of applicant applying for the CARN PART 2 EXPERIENCE	NAME: Print Name
COMPLETE ALL BLANK FIELDS.       Check Here         The applicant's dates of experience were from:       Image: Check Here	Title:
START DATE: END DATE: If Currently Employed	Credentials (if any)
Month Year Month Year	Phone
Averaging hours (per week) at this facility in <i>addictions nursing experience.</i>	Email
EXPERIENCE HOURS WERE IN THE FOLLOWING CAPACITY (Check all that may apply):	PART 5 FACILITY/SITE
□ Staff Nurse □ Consultation	Practice Setting/Institution Name
□ Administrative □ Teaching	Fractice Setting/Institution Name
□ Counseling □ Research	
<b>PART 3</b> EXPERIENCE DESCRIPTION Use this section if further explanation of the candidate's	City ST
experience is required.	PART 5SUPERVISOR SIGNATURE
	I attest that the information provided on this page is, to the best of my knowledge, accurate:
	Signature:
	Date

### **SECTION 8: VERIFICATION OF CONTINUING EDUCATION**

Applicants are required to provide evidence of having a minimum of 30 hours of continuing education. These hours and the related information must be tallied using this form and must be applicable to addictions nursing. Actual continuing education certificates should not be included but must be made available upon request. These educational units must have occurred within the last three (3) years. The completed form attesting to 30 hours of continuing education in addictions nursing must be returned with the certification application. If necessary, please make additional copies of page 17.

If necessary, please make addition	nal copies of page 17.		
	5 Hours Accrued   Date Completed: 06   21   21		
	Activity Sponsor:	Medscape	
	Title of Program: Opioids in		
щ	<u>Inde of Program. Opwas ac</u>	Suburbun Populucions	
EXAMPL	Type of Program: (Choose (	Dne)	
Ξ	✓ Online home study, self-p	baced	
A	Live webinar		
×	In person seminar/confer		
ш	Applicability to Addictions:	, ,	
	<ul> <li>✓ Directly in addictions (SU</li> </ul>		
	□ Related/co-occurring, (de	epression, HIV, PTSD, etc.)	
<b>-</b>	VERIFICATION OF 30 CON		
	d additional fees, you must co	omplete ALL spaces in this section.	
Hours Accrued   Date	e Completed: / /	Hours Accrued   Date Completed: / /	
Activity Sponsor:		Activity Sponsor:	
		Title of Program:	
Type of Program: (Choose Or	ne)	Type of Program: (Choose One)	
<ul> <li>Online home study, self-pa</li> </ul>		Online home study, self-paced	
□ Live webinar		□ Live webinar	
In person seminar/conference	nce	In person seminar/conference	
Applicability to Addictions: (	Choose One)	Applicability to Addictions: (Choose One)	
Directly in addictions (SUD)		<ul> <li>Directly in addictions (SUD, gambling, etc.)</li> </ul>	
□ Related/co-occurring, (depression, HIV, PTSD, etc.)		□ Related/co-occurring, (depression, HIV, PTSD, etc.)	
	e Completed: / /	Hours Accrued   Date Completed: / /	
Activity Sponsor:		Activity Sponsor:	
Title of Program:		Title of Program:	
Type of Program: (Choose Or		Type of Program: (Choose One)	
<ul> <li>Online home study, self-paced</li> </ul>		<ul> <li>Online home study, self-paced</li> </ul>	
□ Live webinar		$\Box$ Live webinar	
□ In person seminar/conferen	nce	□ In person seminar/conference	
Applicability to Addictions: (	Choose One)	Applicability to Addictions: (Choose One)	
Directly in addictions (SUD	), gambling, etc.)	□ Directly in addictions (SUD, gambling, etc.)	
□ Related/co-occurring, (dep	ression, HIV, PTSD, etc.)	□ Related/co-occurring, (depression, HIV, PTSD, etc.)	
		TOTAL HOURS ON PAGE	

### **SECTION 8: VERIFICATION OF CONTINUING EDUCATION**

Photocopy this page as needed.

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	NTACT HOURS FOR CARN	
To avoid additional fees, you must	complete ALL spaces in this section.	
Hours Accrued   Date Completed: / /	Hours Accrued   Date Completed: / /	
Activity Sponsor:	Activity Sponsor:	
Title of Program:	Title of Program:	
<ul> <li>Type of Program: (Choose One)</li> <li>Online home study, self-paced</li> <li>Live webinar</li> <li>In person seminar/conference</li> <li>Applicability to Addictions: (Choose One)</li> <li>Directly in addictions (SUD, gambling, etc.)</li> </ul>	<ul> <li>Type of Program: (Choose One)</li> <li>Online home study, self-paced</li> <li>Live webinar</li> <li>In person seminar/conference</li> <li>Applicability to Addictions: (Choose One)</li> <li>Directly in addictions (SUD, gambling, etc.)</li> </ul>	
<ul> <li>Related/co-occurring, (depression, HIV, PTSD, etc.)</li> </ul>	□ Related/co-occurring, (depression, HIV, PTSD, etc.)	
Hours Accrued   Date Completed: / /	Hours Accrued   Date Completed: / /	
Activity Sponsor:	Activity Sponsor:	
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Hours Accrued   Date Completed: / /	Hours Accrued   Date Completed: / /	
Title of Program:	Title of Program:	
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<ul> <li>Type of Program: (Choose One)</li> <li>Online home study, self-paced</li> <li>Live webinar</li> <li>In person seminar/conference</li> <li>Applicability to Addictions: (Choose One)</li> <li>Directly in addictions (SUD, gambling, etc.)</li> </ul>	<ul> <li>Type of Program: (Choose One)</li> <li>Online home study, self-paced</li> <li>Live webinar</li> <li>In person seminar/conference</li> <li>Applicability to Addictions: (Choose One)</li> <li>Directly in addictions (SUD, gambling, etc.)</li> </ul>	
<ul> <li>Related/co-occurring, (depression, HIV, PTSD, etc.)</li> </ul>	<ul> <li>Related/co-occurring, (depression, HIV, PTSD, etc.)</li> </ul>	

Related/co-occurring, (depression, HIV, PTSD, etc.) 

TOTAL HOURS ON PAGE