CARN

Certified Addictions Registered Nurse

Examination Application

Includes Pages 10 - 15

INSTRUCTIONS:
Complete 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**

Application Checklist:

All items must be returned together with certification fee

- ☐ Signed Application Form
- ☐ Data Form
- ☐ Verification Form (2000 hours of related practice)
- ☐ Verification of 30 Contact Hours in addiction nursing
- ☐ Copy of RN License showing expiration date
- ☐ A Copy of your current government issued photo ID

Be advised: Incomplete applications are subject to an Incomplete Application Fee.

SECTION 1: CANDIDATE INFORMATION

To avoid additional fees you must complete ALL spaces 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 _____
Current Legal Last Name | Maiden | Legal First Name | Middle Name

MAILING 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 PHONE NUMBER _____ WORK NUMBER _____

SECTION 2: RN LICENSE

To avoid additional fees you must complete ALL spaces in this section

STATE: _____ PERMANENT NUMBER: _____

DATE OF ORIGINAL LICENSE: _____ EXPIRATION DATE: _____

SECTION 3: APPLICANT SIGNATURE

To avoid additional fees you must complete ALL spaces 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.

_____ _____
Legal Signature Date

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 thirty (30) contact hours of continuing education on the verification form supplied in this 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.

SECTION 5: PAYMENT Please enclose one of the following valid forms of payment. **Make checks payable to C-NET**

☐ $300.00 **STANDARD EXAM FEE** **Enclosed:** ☐ **Money Order/ Check** ☐ **Credit Card** (Complete below)

☐ $250.00 **Membership Discount**

To receive a $50 discount, applicants must attach proof of current membership to one of the following two organizations:

ASAN or IntNSA (USA)

Proof may include a membership card, certificate, or printed confirmation from an online account. Only one $50 discount is allowed. Insufficient proof will result in the full exam fee being charged.

APPLICANT NAME _____

CARD HOLDER NAME
(If different than above) _____

Visa or Master Card Only:

CARD NUMBER _____ _____ _____ _____

Exp Date _____ Phone Number _____

AUTHORIZATION
SIGNATURE: _____ DATE: _____

PLEASE NOTE: **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.**

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
- ☐ 51+ years

Years of RN experience in addictions nursing:
- ☐ 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
- ☐ 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:
- ☐ No
- ☐ 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
- ☐ Codependency/Family

Age group you mostly work with:
- ☐ Newborns
- ☐ Infants/Children
- ☐ Adolescents (age 12-20)
- ☐ Adults (age 21-64)
- ☐ Older Adults (age 65 and up)

Current professional membership?
- ☐ International Nurses Society on Addictions (IntNSA)
- ☐ State Nurses Association
- ☐ National League for Nursing
- ☐ Sigma Theta Tau International
- ☐ Other

How did you hear about this certification?
- ☐ Nursing Journal
- ☐ IntNSA Newsletter
- ☐ Colleague Marketing
- ☐ Marketing
- ☐ IntNSA Website
- ☐ Other Website
- ☐ Employer
- ☐ Other

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 **all sections** 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:

_____

Print first and last name of applicant applying for the CARN

PART 2 EXPERIENCE

COMPLETE ALL BLANK FIELDS. Check Here ☐

The applicant's dates of experience were from:

START DATE: END DATE: If Currently Employed

Month____ Year _____ Month____ Year _____

Averaging _____ hours (per week) at this facility in ***addictions nursing experience.***

EXPERIENCE HOURS WERE IN THE FOLLOWING CAPACITY (Check all that may apply):

☐ Staff Nurse ☐ Consultation

☐ Administrative ☐ Teaching

☐ Counseling ☐ Research

PART 3 EXPERIENCE DESCRIPTION

Use this section if further explanation of the candidate's experience is required.

PART 4 SUPERVISOR INFORMATION

NAME: _____

Print Name

Title: _____

Credentials (if any) _____

Phone _____

Email _____

PART 5 FACILITY/SITE

_____

Practice Setting/Institution Name

_____

City ST

PART 5 SUPERVISOR 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.

EXAMPLE

[5] **Hours Accrued | Date Completed**: 06 / 21 / 21

Activity Sponsor: Medscape

Title of Program: Opioids in Suburban Populations

Type of Program: (Choose One)

- [x] Online home study, self-paced
- [ ] Live webinar
- [ ] In person seminar/conference

Applicability to Addictions: (Choose One)

- [x] Directly in addictions (SUD, gambling, etc.)
- [ ] Related/co-occurring, (depression, HIV, PTSD, etc.)

VERIFICATION OF 30 CONTACT HOURS FOR CARN

To avoid additional fees, you must complete ALL spaces in this section.

[ ] **Hours Accrued | Date Completed**: ___/___/___

Activity Sponsor: ____________________

Title of Program: ____________________

____

Type of Program: (Choose One)

- [ ] Online home study, self-paced
- [ ] Live webinar
- [ ] In person seminar/conference

Applicability to Addictions: (Choose One)

- [ ] Directly in addictions (SUD, gambling, etc.)
- [ ] Related/co-occurring, (depression, HIV, PTSD, etc.)

[ ] **Hours Accrued | Date Completed**: ___/___/___

Activity Sponsor: ____________________

Title of Program: ____________________

____

Type of Program: (Choose One)

- [ ] Online home study, self-paced
- [ ] Live webinar
- [ ] In person seminar/conference

Applicability to Addictions: (Choose One)

- [ ] Directly in addictions (SUD, gambling, etc.)
- [ ] Related/co-occurring, (depression, HIV, PTSD, etc.)

[ ] **Hours Accrued | Date Completed**: ___/___/___

Activity Sponsor: ____________________

Title of Program: ____________________

____

Type of Program: (Choose One)

- [ ] Online home study, self-paced
- [ ] Live webinar
- [ ] In person seminar/conference

Applicability to Addictions: (Choose One)

- [ ] Directly in addictions (SUD, gambling, etc.)
- [ ] Related/co-occurring, (depression, HIV, PTSD, etc.)

[ ] **Hours Accrued | Date Completed**: ___/___/___

Activity Sponsor: ____________________

Title of Program: ____________________

____

Type of Program: (Choose One)

- [ ] Online home study, self-paced
- [ ] Live webinar
- [ ] In person seminar/conference

Applicability to Addictions: (Choose One)

- [ ] Directly in addictions (SUD, gambling, etc.)
- [ ] Related/co-occurring, (depression, HIV, PTSD, etc.)

[ ] **TOTAL HOURS ON PAGE**

SECTION 8: VERIFICATION OF CONTINUING EDUCATION	Photocopy this page as needed.

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 this form.

VERIFICATION OF 30 CONTACT HOURS FOR CARN
To avoid additional fees, you must complete ALL spaces in this section.

☐ **Hours Accrued | Date Completed**:___/___/____
Activity Sponsor: ____________________
Title of Program: ____________________
____
Type of Program: (Choose One)
☐ Online home study, self-paced
☐ Live webinar
☐ In person seminar/conference
Applicability to Addictions: (Choose One)
☐ Directly in addictions (SUD, gambling, etc.)
☐ Related/co-occurring, (depression, HIV, PTSD, etc.)

☐ **Hours Accrued | Date Completed**:___/___/____
Activity Sponsor: ____________________
Title of Program: ____________________
____
Type of Program: (Choose One)
☐ Online home study, self-paced
☐ Live webinar
☐ In person seminar/conference
Applicability to Addictions: (Choose One)
☐ Directly in addictions (SUD, gambling, etc.)
☐ Related/co-occurring, (depression, HIV, PTSD, etc.)

☐ **Hours Accrued | Date Completed**:___/___/____
Activity Sponsor: ____________________
Title of Program: ____________________
____
Type of Program: (Choose One)
☐ Online home study, self-paced
☐ Live webinar
☐ In person seminar/conference
Applicability to Addictions: (Choose One)
☐ Directly in addictions (SUD, gambling, etc.)
☐ Related/co-occurring, (depression, HIV, PTSD, etc.)

☐ **Hours Accrued | Date Completed**:___/___/____
Activity Sponsor: ____________________
Title of Program: ____________________
____
Type of Program: (Choose One)
☐ Online home study, self-paced
☐ Live webinar
☐ In person seminar/conference
Applicability to Addictions: (Choose One)
☐ Directly in addictions (SUD, gambling, etc.)
☐ Related/co-occurring, (depression, HIV, PTSD, etc.)

☐ **Hours Accrued | Date Completed**:___/___/____
Activity Sponsor: ____________________
Title of Program: ____________________
____
Type of Program: (Choose One)
☐ Online home study, self-paced
☐ Live webinar
☐ In person seminar/conference
Applicability to Addictions: (Choose One)
☐ Directly in addictions (SUD, gambling, etc.)
☐ Related/co-occurring, (depression, HIV, PTSD, etc.)

☐ **Hours Accrued | Date Completed**:___/___/____
Activity Sponsor: ____________________
Title of Program: ____________________
____
Type of Program: (Choose One)
☐ Online home study, self-paced
☐ Live webinar
☐ In person seminar/conference
Applicability to Addictions: (Choose One)
☐ Directly in addictions (SUD, gambling, etc.)
☐ Related/co-occurring, (depression, HIV, PTSD, etc.)

☐ **TOTAL HOURS ON PAGE**