



**ANCC proudly offers certification for**

# Advanced Diabetes Management

The Advanced Diabetes Management health care professional has an advanced degree as either a Clinical Nurse Specialist, Nurse Practitioner, Registered Dietitian, or Registered Pharmacist and is able to: 1) perform complete and/or focused assessments; 2) recognize and prioritize complex data in order to identify needs of patients with diabetes across the life span, and 3) provide therapeutic problem-solving, counseling, and regimen adjustments. The scope of advanced diabetes practice includes management skills such as medication adjustment, medical nutrition therapy, exercise planning, counseling for behavior management, and psychosocial issues. Attaining optimal metabolic control may include treatment and monitoring of acute and chronic complications. The depth of knowledge and competence in advanced clinical practice and diabetes skills affords an increased complexity of decision making, which expands the traditional discipline specific practice. Research, publications, mentoring, and continuing professional development are expected skill sets.

For eligibility criteria, see inside.

For more information: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## Eligibility Criteria

# Advanced Diabetes Management

### *Clinical Nurse Specialist/Nurse Practitioner Eligibility Criteria*

- > Hold a current, active RN license in a state or territory of the United States or the professional, legally recognized equivalent in another country.
- > Hold licensure, registration and/or certification as a clinical nurse specialist or nurse practitioner
- > Within 48 months prior to applying for this certification exam, complete a minimum of 500 clinical practice hours in advanced diabetes management after licensure and/or certification as a clinical nurse specialist or nurse practitioner. Complete the enclosed Advanced Diabetes Management Board Certification Examination Validation of Clinical Practice form.

### **Or**

- > Hold a current, active RN license in a state or territory of the United States or the professional, legally recognized equivalent in another country.
- > Hold a master's, post-master's, or doctoral degree from a clinical nurse specialist or nurse practitioner advanced diabetes management 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 in the CNS or NP Advanced Diabetes Management role and specialty must be included in the educational program. The Advanced Diabetes CNS and NP graduate program must include course work in:
  - > advanced health assessment
  - > advanced pharmacology
  - > advanced pathophysiology
  - > NPs must also have health promotion and disease prevention, and differential diagnosis and disease management

**Important Note:** Check with your state board of nursing to determine if this certification meets state licensure requirement as a clinical nurse specialist or nurse practitioner.

### *Registered Dietitian Eligibility Criteria*

- > Hold a current, active Dietitian registration in a state or territory of the United States or the professional, legally recognized equivalent in another country.
- > Hold a Master's or higher degree in a clinically relevant area, such as Nutrition, Public Health, Education (Med), Exercise, Sports Nutrition, Counseling, or Gerontology.
- > Within 48 months prior to applying this certification exam, complete a minimum of 500 hours of clinical practice in advanced clinical diabetes management after obtaining registration as a Dietitian. Complete the enclosed Advanced Diabetes Management Board Certification Examination Validation of Clinical Practice form.

### *Registered Pharmacist-Eligibility Criteria*

- > Hold a current, active Pharmacist registration in a state or territory of the United States or the professional, legally recognized equivalent in another country.
- > Hold a Master's or higher degree in Pharmacy or currently practicing in a state that recognizes collaborative diabetes clinical practice.
- > Within 48 months prior to applying this certification exam, complete a minimum of 500 hours of clinical practice in advanced clinical diabetes management after obtaining registration as a Pharmacist. Complete the enclosed Advanced Diabetes Management Board Certification Examination Validation of Clinical Practice form.

**All requirements must be completed prior to application for the examination.  
An incomplete application affects a candidate's ability to test.**

**For more information:**[www.nursecredentialing.org](http://www.nursecredentialing.org)

# Advanced Diabetes Management

**Overview of test content outline** For full test content outline, go to [www.nursecredentialing.org](http://www.nursecredentialing.org)

## I. Clinical Practice

- A. Assessment and data collection
- B. Diagnosis/problem identification
- C. Planning & intervention

## II. Collaboration

- A. Clinical coordination & case management
- B. Consultant role

## III. Public & Community Health

- A. Public health trends & epidemiology
- B. National health initiatives
- C. Prevention strategies & programs

## IV. Research

- A. Identification of research problems
- B. Research design & methodology
- C. Study coordination
- D. Translation, dissemination, & utilization of research findings

## V. Leadership & Professional Practice

- A. Organizational & management issues
- B. Continuous quality improvement
- C. Legal & ethical issues
- D. Scope and standards of practice
- E. Professional development
- F. Regulatory, accreditation, recognition, & reimbursement programs and standards for institutions & providers

## 2008-2009 Application Fees

 Includes \$140 non-refundable appraisal fee

<b>ANA &amp; AAE Members</b>	\$270	Required attachment: A copy of your American Nurses Association or American Association of Diabetes Educators membership card
<b>Discount</b>	\$340	Attach a copy of your American Diabetes Association, American Dietetic Association, American Pharmacist Association, American College of Nurse Practitioners, or National Association of Clinical Nurse Specialists membership card
<b>Non-Member</b>	\$390	
<b>Additional Special Fees:</b>		
<b>International Testing</b>	\$125	See <a href="http://www.nursecredentialing.org">www.nursecredentialing.org</a> 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, ineligible to test, and other frequently asked questions is in the General Testing and Renewal Handbook available at [www.nursecredentialing.org](http://www.nursecredentialing.org). From this website, you can type into, save, and print your application. Please sign, attach required documents, 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](http://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](http://www.nursecredentialing.org) or call 1.800.284.2378.

## Mailing Instructions

Print legibly using either black or blue ink. Submit an application, copy of RN license, and payment. Remember to attach all required supporting documents and mail to:

**American Nurses Credentialing Center  
P.O. Box 791333  
Baltimore, MD 21279-1333**

# Advanced Diabetes Management

## General Information

1

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

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City State Zip/Postal Country

\_\_\_\_\_  
Home Phone Home Fax Personal E-Mail

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Employer Address

\_\_\_\_\_  
City State Zip/Postal

\_\_\_\_\_  
Work Phone Work Fax Work E-Mail

### Type of primary position:

- |                                                           |                                                            |                                                    |
|-----------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Nurse Manager                    | <input type="checkbox"/> Associate/Assistant Administrator | <input type="checkbox"/> Clinical/Staff Nurse      |
| <input type="checkbox"/> Nurse Practitioner               | <input type="checkbox"/> Educator                          | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Administrator/DON/CNO/VP Nursing | <input type="checkbox"/> Researcher                        | <input type="checkbox"/> Consultant                |
|                                                           |                                                            | <input type="checkbox"/> Other: _____              |

### I am applying for the following exam:

- |                                                    |                                     |
|----------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Dietitian  |
| <input type="checkbox"/> Nurse Practitioner        | <input type="checkbox"/> Pharmacist |

## Payment

2

Personal Check/Money Order (payable to ANCC) Amount Enclosed: \_\_\_\_\_

Charge Card (MasterCard or VISA only) Amount to be charged: \_\_\_\_\_

Promotional Code (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Account Number Exp. Date

\_\_\_\_\_  
Print Name on Card Signature

## Special Accommodations/Americans with Disabilities Act

3



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](http://www.nursecredentialing.org)

## Validation of Clinical Practice Form

### INSTRUCTIONS

Each health care professional providing all or a portion of your supervised 500 hours of advanced diabetes clinical practice must complete this form. All information must be written legibly in either blue or black ink. Include the completed form(s) with your application packet.

Candidate's Name (Last, First, MI)

Social Security Number

**1. List the sites, dates, responsibilities, and number of clinical hours in which you demonstrated advanced clinical practice in managing patients with diabetes. (Attach additional sheets as needed)**

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Applicant's Signature

Date

**2. Completed by the supervisor or peer providing the clinical consultation or supervision:**

Print Name of Supervisor or Peer

Supervisor or Peer Position and/or Title

Facility Name

Facility Address

Telephone number

E-mail

**3. Number of hours of clinical observation or supervision you provided for this candidate:** \_\_\_\_\_

**4. Dates of the observation or supervision occurred from:** \_\_\_\_\_ **to** \_\_\_\_\_

**5. Describe the clinical observation or supervision (attach additional sheets as needed):**

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**Check one**

- I endorse the above-named individual's application to take the examination for Advanced Diabetes Management Board Certification. The person fulfilled the responsibilities as described above. In my judgment, the candidate is qualified to function in an Advanced Diabetes Management role. To the best of my knowledge, this person's practice and conduct conform to accepted professional and ethical standards.
- I cannot endorse the above-named individual's application to take the examination for Advanced Diabetes Management Board Certification.

Supervisor or Peer Name Signature

Date

## 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 (do not include high school).

**Required attachment:** All official advanced degree transcripts.

Please attach additional page if necessary.

School Name

School Code

Major/Area of Study

Date Degree Conferred

School Name

School Code

Major/Area of Study

Date Degree Conferred

### School codes:

Available on-line at [www.nursecredentialing.org/certapp/schoolcodes.cfm](http://www.nursecredentialing.org/certapp/schoolcodes.cfm)

## Licensure Information

**Required attachment:** Attach a copy of license

Current License/Registration Number

State

Expiration Date (month/date/year)

## Statement of Understanding

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

I authorize the Commission on Certification to make whatever inquiries and investigations that it deems necessary to verify my credentials and professional standing. I expressly acknowledge 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.

To the best of my knowledge, the information on this application is true, complete, and correct. I attest by my signature that I meet all eligibility requirements for certification, in effect for the year in which this application is made as stipulated in the most current requirements on the ANCC website: [www.nursecredentialing.org](http://www.nursecredentialing.org) I attest by my signature that I will maintain an active registered nurse licensure throughout the entire period during which I am certified. I understand that any misstatement of any material fact submitted upon application for certification may be sufficient cause for ANCC to bar me from the examination, to invalidate the results of my examination, to withhold certification, to revoke certification, or to take other appropriate action.

I hereby attest that I meet the eligibility criteria as stated on the front of this brochure and ANCC website for this certification exam.

*(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 a registered nurse/licensed practitioner (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  
 Post-partum  
 Labor & Delivery  
 Pediatrics  
 ER  
 Trauma  
 Critical Care  
 Other: \_\_\_\_\_
9. Age range of your primary patient population:  
 0–1  
 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 tradeshow  
 Other: \_\_\_\_\_
14. Please check the professional organizations in which you are a member (check all that apply):
- |                                                                                                     |                                                                                          |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation | <input type="checkbox"/> ASPMN American Society for Pain Management Nursing              |
| <input type="checkbox"/> AADE American Association of Diabetes Educators                            | <input type="checkbox"/> ISPN International Society of Psychiatric-Mental Health Nurses  |
| <input type="checkbox"/> AAACN American Academy of Ambulatory Care Nursing                          | <input type="checkbox"/> NACNS National Association of Clinical Nurse Specialists        |
| <input type="checkbox"/> ACNP American College of Nurse Practitioners                               | <input type="checkbox"/> NCGNP National Conference of Gerontological Nurse Practitioners |
| <input type="checkbox"/> ADA American Diabetes Association                                          | <input type="checkbox"/> NGNA National Gerontological Nursing Association                |
| <input type="checkbox"/> ADA American Dietetic Association                                          | <input type="checkbox"/> NNSDO National Nursing Staff Development Organization           |
| <input type="checkbox"/> ANI Alliance for Nursing Informatics                                       | <input type="checkbox"/> PCNA Preventive Cardiovascular Nurses Association               |
| <input type="checkbox"/> APhA American Pharmacists Association                                      | <input type="checkbox"/> SPN Society of Pediatric Nurses                                 |
| <input type="checkbox"/> APNA American Psychiatric Nurses Association                               | <input type="checkbox"/> SVN Society for Vascular Nursing                                |
| <input type="checkbox"/> APHA American Public Health Association (Public Health Nursing Section)    | <input type="checkbox"/> Other: _____                                                    |
| <input type="checkbox"/> ANA American Nurses Association                                            |                                                                                          |

## 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

- |                                                        |                                          |
|--------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Asian/Pacific Islander        | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black/African-American        | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Hispanic                      |                                          |

## Validation of Nurse Practitioner Education Program

### INSTRUCTIONS

Nurse Practitioners who graduated from an academic program that included 500 hours of clinical practice in advanced diabetes management should use this form instead of section 4 of the application.

Candidate: Allow sufficient time for the program director to complete and return this form to you for inclusion with your application. Applications received without this form or with an incomplete form incur a delay that can impact your ability take the exam.

The current program director completes items 1-10 and returns the form to the candidate to include with an application.

Please type or print all information.

\_\_\_\_\_  
Candidate's Name (Last, First, MI)

\_\_\_\_\_  
Social Security Number

#### 1. The individual named above graduated from:

\_\_\_\_\_  
Name of University/School

\_\_\_\_\_  
School Code  
(Available at [www.nursecredentialing/cert/schoolcodes.cfm](http://www.nursecredentialing/cert/schoolcodes.cfm))

\_\_\_\_\_  
Program Name

\_\_\_\_\_  
Program Address

\_\_\_\_\_  
Program Telephone Number

#### 2. Type of degree conferred:

- Master's nurse practitioner program
- Post-Master's nurse practitioner program  
(Required Attachment: Provide a detailed description of the course work and clinical hours accepted from previous graduate programs.)
- Doctorate

3. Date program completed: \_\_\_\_\_

4. Date degree conferred: \_\_\_\_\_

#### 5. Check area of concentration completed:

- Acute Care Nurse Practitioner
- Adult Nurse Practitioner
- Adult Psychiatric-Mental Health Nurse Practitioner
- Advanced Diabetes Management Nurse Practitioner
- Family Nurse Practitioner
- Family Psychiatric-Mental Health Nurse Practitioner
- Gerontological Nurse Practitioner
- Pediatric Nurse Practitioner

10. **Program Director Signature** Your signature on this form attests that the above named individual has completed the program indicated on this document.

\_\_\_\_\_  
Program Director (Print Name)

\_\_\_\_\_  
Program Director's Signature

\_\_\_\_\_  
Date

#### 6. Please indicate the title and course number of the following content:

Advanced Health Assessment \_\_\_\_\_

Pharmacology \_\_\_\_\_

Pathophysiology \_\_\_\_\_

Diagnosis and medication management of psychiatric illness (**Psychiatric and Mental Health Nurse Practitioners only**) \_\_\_\_\_

#### 7. For Psychiatric-Mental Health Nurse Practitioner Specialty Only

Please check the psychotherapeutic treatment modalities in which the candidate received supervised clinical training at the graduate or post graduate level:

- Individual       Group
- Family             Expressive Therapies
- Milieu               Play Therapy
- Other

8. Total number of Didactic: \_\_\_\_\_  
(in credit hours)

9. Total number of Clinical: \_\_\_\_\_  
(in clock hours)

## Validation of Clinical Nurse Specialist Education Program

### INSTRUCTIONS

Clinical Nurse Specialists who graduated from an academic program that included 500 hours of clinical practice in advanced diabetes management should use this form instead of section 4 of the application.

Candidate: Allow sufficient time for the program director to complete and return this form to you for inclusion with your application. Applications received without this form or with an incomplete form incur a delay that can impact your ability take the exam.

The current program director completes items 1-10 and returns the form to the candidate to include with an application.

Please type or print all information.

\_\_\_\_\_  
Candidate's Name (Last, First, MI)

\_\_\_\_\_  
Social Security Number

#### 1. The individual named above graduated from:

\_\_\_\_\_  
Name of University/School

\_\_\_\_\_  
School Code  
(Available at [www.nursecredentialing/cert/schoolcodes.cfm](http://www.nursecredentialing/cert/schoolcodes.cfm))

\_\_\_\_\_  
Program Name

\_\_\_\_\_  
Program Address

\_\_\_\_\_  
Program Telephone Number

#### 2. Type of degree conferred:

- Master's clinical nurse specialist program
- Post-Master's clinical nurse specialist program  
(**Required Attachment:** Provide a detailed description of content and clinical hours accepted from all previous graduate programs.)
- Doctorate

**3. Date program completed:** \_\_\_\_\_

**4. Date degree conferred:** \_\_\_\_\_

#### 5. Check area of concentration completed:

- Adult Health Clinical Nurse Specialist
- Adult Psychiatric-Mental Health Clinical Nurse Specialist
- Advanced Diabetes Management Clinical Nurse Specialist
- Child/Adolescent Psychiatric & Mental Health Clinical Nurse Specialist
- Gerontological Clinical Nurse Specialist
- Pediatric Clinical Nurse Specialist
- Public/Community Health Clinical Nurse Specialist

**10. Program Director Signature** Your signature on this form attests that the above named individual has completed the program indicated on this document.

\_\_\_\_\_  
Program Director (Print Name)

\_\_\_\_\_  
Program Director's Signature

#### 6. Please indicate the title and course number of the following content:

Advanced Health Assessment \_\_\_\_\_

Pharmacology \_\_\_\_\_

Pathophysiology \_\_\_\_\_

#### 7. For Psychiatric-Mental Health Specialty Only

Please check the psychotherapeutic treatment modalities in which the candidate received supervised clinical training at the graduate or post graduate level:

- Individual       Group
- Family           Expressive Therapies
- Milieu            Play Therapy
- Other

**8. Total number of Didactic:** \_\_\_\_\_  
(in credit hours)

**9. Total number of Clinical:** \_\_\_\_\_  
(in clock hours)

\_\_\_\_\_  
Date

# To Do List

## Date completed:

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Read this entire application, front to back.

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

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

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

## STUDY PLAN

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Approximately six 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 on-line 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.

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

## FILL OUT THE APPLICATION

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Two to three 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 nursing 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)

Payment (if you are paying by check)

## Attachments for special circumstances:

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

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Mail your application and attachments to:

**American Nurses Credentialing Center**

**P.O. Box 791333**

**Baltimore, MD 21279-1333**

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

## RESULTS

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After you have taken your exam, you will receive results in the mail within two weeks. If you passed, you will receive a certificate and pin within two months. Certifications are good for 5 years.

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Request your one free verification of certification at **www.nursecredentialing.org** using the paper form. Please note, you can not request a free verification using the on-line system.

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After you pass the exam, download the Certification Renewal materials from the ANCC website at **www.nursecredentialing.org** and begin tracking your renewal requirements.

# Exam Preparation Resources

## Review Seminars

Review Seminars for certification exams are available for fifteen different nursing specialties at various hospitals and schools of nursing across the country. Participants receive contact hours. Seminar schedule and registration at: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## Study Groups

Using the content from the seminars, the faculty lecture on the material during several telephone conference calls scheduled during a specific time period. Look for the "Study Group" courses in the seminar schedule. Participants receive contact hours. Study Group schedule and registration at: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## On-Line Narrated Review Courses

Our On-Line Narrated Review Courses contain the same content as our popular Review Seminars, with the voice over of an instructor talking the student through the material. After you register for the course, you will have three months in which to complete the materials. Participants receive contact hours. For more information and to register: [www.nursecredentialing.org](http://www.nursecredentialing.org)

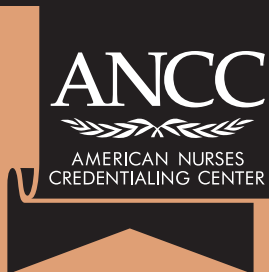
## Review and Resource Manuals

Written by nursing experts in each specialty, these manuals help candidates prepare for a variety of certification exams by enhancing your critical thinking skills and identifying strengths and weaknesses. Contact hours available on-line for an additional fee. Order manuals at: [www.nursecredentialing.org](http://www.nursecredentialing.org)

## Certified Nurse Products

Once you have passed your exam, celebrate your accomplishment with pins, plaques, and other recognition items. [www.nursecredentialing.org](http://www.nursecredentialing.org)

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), provides individuals and organizations throughout the nursing profession with the resources they need to achieve practice excellence. ANCC's internationally renowned credentialing programs certify nurses in specialty practice areas; recognize healthcare organizations for promoting safe, healthy work environments through the Magnet Recognition Program® and the Pathway to Excellence Program™; and accredit providers of continuing nursing education. In addition, ANCC provides leading-edge information and education services and products to support its core credentialing programs. All programs of the ANCC are administered without discrimination on the basis of age, color, creed, disability, gender, health status, lifestyle, nationality, race, religion, or sexual orientation. ANA is accredited as a provider of continuing nursing education by ANCC's Commission on Accreditation. ANA is approved as a provider by the California Board of Registered Nursing, Provider number 6178.



P.O. Box 791333  
Baltimore, MD 21279-1333  
1.800.284.2378

[www.nursecredentialing.org](http://www.nursecredentialing.org)

DIAB08v3 2M 08/08