

**Radiologic Nursing
Certification Board, Inc.**



**RADIOLOGIC NURSING CERTIFICATION BOARD (RNCB®)
APPLICATION FOR CERTIFICATION COVER LETTER**

Congratulations on your decision to become certified in Radiologic Nursing in Imaging, Interventional, and Therapeutic Environments. Please visit www.certifiedradiologynurse.org to download the Guidelines for Certification & Recertification to assist you in preparing your application materials.

Incomplete applications will not be processed*. A complete application packet includes the following items:

- Fully completed certification application form
- Proof of current ARIN Membership with expiration date (if seeking discount)-printed screenshot from www.arinursing.org is acceptable
- Copy of current nursing license -printed screenshot showing name and expiration date from licensing body is acceptable
- Completed contact hour documentation form included with application (page 4). If you prefer a workable Excel file you can download it at www.certifiedradiologynurse.org
- Appropriate payment amount, including any late fees that apply (see www.certifiedradiologynurse.org for late fee dates that may apply)

Certification

ARIN MEMBERS-\$325 ARIN Expiration Date _____
(Application Fee \$25 + Examination Fee \$300)

NON MEMBERS-\$425
(Application Fee \$25 + Examination Fee \$400)

Late Fee: \$45 Exam applications received up to 14 days past application deadline

The late fee must be included with registration after the established deadlines (see www.certifiedradiologynurse.org). Application fee, late fee and special fees are non-refundable and non-transferable to another year.

PAYMENT:

Amount enclosed: _____

Charge Card (Amount to be charged): _____ Master Card Visa American Express

Card # _____ Exp. Date _____ CVV# _____

Signature on this Account: _____

By signing this cover letter to accompany my application for certification I acknowledge that incomplete applications will not be accepted. I acknowledge that if my application is not accepted I may resubmit when I have completed the missing documentation and that I will be responsible for any late fees that may apply at the time I resubmit.

Printed Name _____

Signature _____ Date _____

You will be notified, via the e-mail you provided, when your application has been received. If you have not received an e-mail within 10 days of submitting your application please call the RNCB national office at 888-878-RNCB (7622) to verify receipt.

***Keep a copy of your entire application for your records. Incomplete applications will not be processed. You will be notified if your application has not been accepted.**

CRN CERTIFICATION
RADIOLOGIC NURSING CERTIFICATION BOARD (RNCB®)
Certification Examination for Radiologic Nursing in Imaging, Interventional,
and Therapeutic Environments

Application materials that are illegible, incomplete, or not accompanied by the proper fee and appropriate documentation will be returned.

PERSONAL DATA Please print or type your name as you would like it to appear on your certificate.			
Last Name	First Name	MI	
Number and Street	City	State	Zip Code
Country (if other than USA)		E-mail Address	
Home Phone		Office Phone	

APPLICATION FOR COMPUTER BASED EXAM: (Please Indicate)

CERTIFICATION
 FIRST TIME
 RETEST
 RETEST CERTIFICATION LAPSED
 Exam Date Requested: _____ **APRIL 2019** **SEPTEMBER 2019**
www.certifiedradiologynurse.org

Test Site options will be provided based on your location once your application has been approved. For a list of test site locations visit www.certifiedradiologynurse.org

LICENSURE INFORMATION

1. CURRENT LICENSURE
 RN License Number _____ State: _____ Exp. Date: _____
2. Submit a photocopy of your current license with this application; printed website screenshots from your licensing state are acceptable if you do not have a card.

VERIFICATION OF PROFESSIONAL QUALIFICATIONS

Two responsible practitioners in the specialty area, one in a supervisory position, must be able to verify that the applicant meets the radiology nursing practice requirements below:

1. Have practiced as a licensed registered nurse a **minimum** of 2,000 hours in radiology nursing practice within the past 3 years. Certification. **-and-**
2. Have been engaged in radiology nursing practice an **average** of 8 hours per week.

These eligibility requirements may be met if you have been engaged in direct patient care or direct clinical management, supervision, education, or direction of other persons to achieve or help achieve patient/client goals for the stated number of hours. Please complete all information.

Name _____	Name _____
Title _____	Title _____
Institution _____	Institution _____
City _____ State _____	City _____ State _____
Contact Phone Number _____	Contact Phone Number _____
Email _____	Email _____

DEMOGRAPHICS

Please fill in the box for ALL levels of education completed:

- 01 Diploma
02 Associate Degree in Nursing
03 Baccalaureate in Nursing
04 Baccalaureate in Other Field
05 Master's in Nursing
06 Master's in Other Field
07 PhD in Other Field
08 EdD
09 DNSc
10 PhD in Nursing
a Undergraduate Institution: _____
Major: _____
Date Degree Completed: _____
b Graduate Institution: _____

Sex: Male Female

Primary field/place of employment (check one box):

- 01 Hospital
02 Nursing Home/Long Term Care
03 Home Health
04 Nurse Managed Practice Group Center
05 Private Practice
06 Public Health
07 School Health
08 Office Nursing (Physician/Dentist)
09 Occupational Health
10 Clinic (Specify): _____
11 Group Practice
12 School of Nursing
13 Other (Specify): _____

Primary Position (check one box):

- 01 Head Nurse or Assistant
02 Staff Nurse
03 Nurse Practitioner
04 Clinical Specialist (Master's degree or above)
05 Nursing Administrator
06 Associate or Assistant Administrator
07 Supervisor or Assistant Supervisor
08 Educator
09 Consultant
10 Researcher
11 Other (Specify): _____

Years of Experience as a registered nurse:

- 1 0-2 16-20
2 3-5 21-25
3 6-10 26-30
4 11-15 Over 30

Total years of experience in the field of radiology nursing:

- 1 0-2 16-20
2 3-5 21-25
3 6-10 26-30
4 11-15 Over 30

Size of facility (total number of beds):

- 1 N/A 251-500
2 1-100 Over 500
3 101-250

Location of facility:

- 1 Urban Rural

STATEMENT OF UNDERSTANDING:

I hereby apply for certification offered by the Radiologic Nursing Certification Board (RNCB®). I understand that I am subject to all requirements of certification as described in the *Guidelines for Certification and Recertification* and that certification depends on successfully completing specified program requirements. If certified, my name will be included on the official listing of certified nurses.

I authorize the RNCB® to make whatever inquiries and investigations that it deems necessary to verify my credentials, professional standing, and participation in continuing education. Information accumulated by RNCB® through the certification process may be used for statistical purposes and for evaluating the program. 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 complete and accurate. I attest that I meet all eligibility requirements for certification as stipulated in the *Guidelines for Certification and Recertification* in effect for the year in which this application is made. I attest that I will maintain active RN licensure throughout the entire period during which I am certified. I understand that misstatement of any material fact submitted upon application for certification may be sufficient cause for RNCB® 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.

Signature: _____

Date: _____

Upload the letter, application, and RNCB® Continuing Education Documentation Form.

If you have questions about the application process or required documentation call 888-878-RNCB (7622) or e-mail admin@certifiedradiologynurse.org

If you have questions about the test, exam sites, or dates, contact the testing center: C-NET, 35 Journal Square, Suite 901, Jersey City, NJ 07306 or (800) 463-0786 or visit www.cnetnurse.com

Radiologic Nursing Certification Board (RNCB®)
Continuing Education Documentation Form

Applicant Name:	Applications for Certification must document 30 contact hours within 2 years of the application date; a minimum of 15 must be radiology specific.						
Submission Date	Applications for recertification must document 60 contact hours within 4 years of your expiration date, with a minimum of 30 being radiology specific.						
Date of education	Contact Hours Received	Indicate if Radiology Specific or General Nursing	Contact hour approval: Name of accrediting provider. Example ASRT, ANCC, ARIN	Course Number and/or Title	If radiology specific describe how it is pertinent to the care of your patient	Accepted (Completed by RNCB® Reviewer)	Comments (Completed by RNCB® Reviewer):

Please copy as needed for additional documentation.