NWCC Initial Examination Application

ANY MISSING OR INCOMPLETE INFORMATION MAY CAUSE DELAY IN PROCESSING - PLEASE PRINT LEGIBLY (5/2018)

1. PRINT NAME (as it appears on your professional license)

Last: First: MI:

2. MAILING ADDRESS
Street:

3. DATE OF BIRTH

City: State/Province: Country: Zip/Postal Code:

Daytime Telephone: ( )
Evening Telephone: ( )
Email: Required for Confirmation

4. PROFESSIONAL TITLE(Check and complete all that apply)

□ RD □ RDN

License Number(s):_____State:_____

ORIGINAL Issue Date:_____ Expiration Date: _____

5. EDUCATION:
□ BS □ Doctoral
□ BA □ Other _____
□ Masters

Field of Study: _____

6. PRIMARY PLACE OF EMPLOYMENT

(Hospital, LTC, LTAC, etc.)

_____

7. ADA ACCOMMODATION

□ YES Special arrangements will be necessary for me to complete the examination. (If yes, contact NAWCO® for instructions.)

8. CERTIFICATION PATHWAY: (Check which one applies.)
□ Experiential
□ Continuing Education
□ Training Course

9. COURSE TYPE: (Check which one applies.)
□ Online □ Onsite
Course Location: _____

Course Date: _____

10. EXAMINATION TYPE

□ On Site at Skin & Wound Management Course
□ Computerized Version at PSI Testing Centers
□ Remote Proctored (Not Available At This Time)

11. APPLICATION EXAMINATION FEES
Non-refundable processing fee. $30
Examination Fees $350.00

TOTAL AMOUNT: _____

12. PAYMENT: CREDIT CARD AUTHORIZATION: Complete this section ONLY if paying by credit card

I, _____, hereby authorize the National Alliance of Wound Care and
(Name exactly as it appears on card)
Ostomy to charge my credit card account for the amount of the fee of $300.00 plus Application fee of $30.00.

❑ Visa ❑ MasterCard ❑ American Express (NO DISCOVER)

Credit Card Number _____ Expiration Date _____/____ Security Code*
_____

*3-digit code found at the end of signature strip

Credit Card Billing Address: (Address where cardholder receives bill)

Street _____

City_____ State_____ Zip_____

Telephone: _____Cardholder Signature: _____Date: _____

13. WORK EXPERIENCE VERIFICATION: Complete the following sections to document required work experience. Must have practiced the equivalent of one (1) year full-time or two (2) years part time in the past five (5) years as a Registered Dietitian/Registered Dietitian Nutritionist

Employer_____

Employer Full Address_____

Employment Dates From: ____ /____ /____ to: ____ /____ /____ □ Current Employer? □ Full Time □ Part Time

Supervisor Name: _____ You must Specify Full or Part Time

Supervisor Phone Number: _____Supervisor Email: _____

Employer_____

Employer Full Address_____

Employment Dates From: ____ /____ /____ to: ____ /____ /____ □ Current Employer? □ Full Time □ Part Time

Supervisor Name: _____ You must Specify Full or Part Time

Supervisor Phone Number: _____Supervisor Email: _____

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14. AUTHORIZATION AND CERTIFICATION INFORMATION RELEASE

I hereby affirm that I am an _____ (license/registration type) currently recognized to practice in the state of _____ .

I further affirm that no licensing authority has current disciplinary action pending against my license to practice in the aforementioned or any other state, and that my license to practice is not currently suspended, restricted or revoked by any state or jurisdiction.

I authorize the National Alliance of Wound Care and Ostomy® to make whatever inquires and investigations that it deems necessary to verify my credentials and professional standing. I further allow the National Alliance of Wound Care and Ostomy® to use information from my application and subsequent examination for the purpose of statistical analysis, provided my personal identification with that information has been deleted.

I hereby understand the National Alliance of Wound Care and Ostomy® will publish my name, professional license type, city, state, past and present certification status under the NAWCO® NWCC™ Certification Directory, in print and electronic versions of a worldwide directory of NAWCO® NWCC™ Certified Practitioners. I release the NAWCO®, its subsidiaries and affiliates and their employees, successors and assigns from any claims of damages for libel, slander, invasion of rights of privacy or publicity, and any other claim based on the publication or release of any Certification Information as specified in this Certification Information Release.

I agree to make claims regarding certification only with respect to the scope for which the certification has been granted. I agree to discontinue use of the NWCC™ credential and promotion of the certification immediately upon expiration, suspension or withdrawal of certification. I further swear to notify the NAWCO® in writing within 10 business days if I learn I am no longer eligible to hold the NWCC™ credential, such as in the event of suspension, placement of restrictions upon or revocation of the primary professional license. I understand that failure to notify the NAWCO® of any of the above listed disciplinary actions will result in revocation of certification and/or denial of recertification. In the event of revocation of the credential, I agree to destroy the Certificate of Certification.

By signing this agreement, I hereby swear and attest to all the contents of the Candidate Agreement/Statement of Understanding contained within the NAWCO® NWCC™ Candidate Handbook. As the applicant, I declare that the foregoing statements are true. I understand false information may be cause for denial or loss of the credential.

_____ _____ _____

Applicant signature Print Name Date