

NAWCO® Recertification Application



ANY MISSING OR INCOMPLETE INFORMATION MAY CAUSE DELAY IN PROCESSING (11/2018)

1. PRINT NAME: (As listed on your Professional License) ALL ITEMS MUST BE COMPLETED TO BE ELIGIBLE FOR RECERTIFICATION

LAST:

FIRST:

MIDDLE:

2. MAILING ADDRESS: (Street, City, State & Zip Code)

3. DAYTIME TELEPHONE #

4. E-MAIL:

5. ADA:

YES NO

6. SELECT CREDENTIAL FOR RECERTIFICATION: WCC DWC LLE OMS NWCC

7. CERTIFICATION #:

8. PROFESSIONAL TITLE (LPN, RN, PT, etc) License Type: _____ License #(s): _____

State: _____ ORIGINAL Issue Date: _____ Expiration Date: _____

9. RECERTIFICATION OPTION: (Indicate your choice and complete additional required forms if applicable)

- Option 1: Examination - No Additional Forms
- Option 2: Training - (Onsite/Online Course) Provider: _____
- Option 3: Continuing Education (CE Verification Form)
- Option 4: Mentoring (WCC ONLY) - Student: _____

10. COURSE TYPE: (Required for Option 2: When Choosing Onsite enter location and dates)

- Online
- Onsite Date: _____
- Location: _____

11. CURRENT EMPLOYER:

12. APPLICATION-CERTIFICATION FEES: Non-Refundable Processing Fee & Recertification Fee \$380.00

13. Agreement Authorization and Certification Information Release

By submitting this NAWCO® Recertification Application, I acknowledge that all supporting documentation provided is true and accurate. If the activities listed on the NAWCO® Activity Report or the supporting verification documents are falsified in any fashion, I understand that this will result in the revocation of my NAWCO® credential.

I affirm that I am currently licensed to practice as a _____ 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® Certification Board to make whatever inquiries and investigations that it deems necessary to verify my credentials and professional standing. I further allow the National Alliance of Wound Care and Ostomy® Certification Board to use information from my application for the purpose of statistical analysis, provided my personal identification with that information has been deleted.

I have read and understand all the information provided in the NAWCO® recertification handbook. I further agree to abide by the policies and procedures as set forth in the NAWCO® recertification handbook and all conditions included in the NAWCO® candidate recertification agreement.

For listing in the National Alliance of Wound Care and Ostomy® Directory, I hereby authorize the National Alliance of Wound Care and Ostomy® its licensees, successors, and assigns (collectively "NAWCO®") the right to publish and release my name, past and present certification status under the NAWCO® Certification Directory, and state/province (collectively "Certification Information") in print and electronic versions of a worldwide directory of NAWCO® "NAWCO®" Certified Practitioners.

If the NAWCO®, is required by law to release your confidential information, you will be notified by email at the address we have on file, unless prohibited by law. 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 NAWCO® 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 NAWCO® 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 any copies of the Certificate of Certification.

By signing this agreement, I hereby swear and attest to all the contents of the Candidate Recertification Agreement Policy/ Statement of Understanding contained within this Candidate Recertification Handbook.

I further agree to abide by the NAWCO® Code of Ethics as set forth and noted in the NAWCO® Recertification Handbook.

Signature: _____ Date: _____

NAWCO® Recertification Application page 2

Applicant Name: _____

14. PAYMENT: CREDIT CARD AUTHORIZATION FORM: 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 \$_____ for _____.

Visa MasterCard American Express (NO DISCOVER)

Credit Card Number _____ Expiration Date ____/____ Security Code* _____
*3-digit code found on signature strip at the end of a series of numbers

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

Street _____

City _____ State _____ Zip _____

Card Holder Email: _____ Telephone: _____

Cardholder Signature: _____ Date: _____