WCC® Certification Application

ANY MISSING OR INCOMPLETE INFORMATION MAY CAUSE DELAY IN PROCESSING - (10/2018)

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:

Mobile Telephone: ( ) Evening Telephone: ( ) Personal Email: Required for Confirmation

4. APPLICATION TYPE: □ Initial Certification □ Lapsed Credential □ Preceptor

5. PROFESSIONAL TITLE (List all that apply, LPN, RN, PT, etc)

License Type: _____

License Number(s):_____ State:_____

ORIGINAL Issue Date:_____ Expiration Date: _____

6. EDUCATION: (Diploma, BS, BSN, etc.)

_____

_____

_____

_____

7. PLACE OF EMPLOYMENT (Hospital, LTC, LTAC, etc.)

_____

8. LICENSED EXPERIENCE/PRACTICE WOUND CARE

□ **< 2 years** □ **2 to 5 years**
□ **>5 but <10 years** □ **>10 years**

9. EDUCATION

□ Online Course (Enter Course Title & Provider)
Course: _____
Provider: _____

□ Onsite Course (Enter Location & Date)
Location: _____
Provider : Dates: _____

□ Certification (Enter Certification and #)
Certification #: _____
Certification #: _____

10. EXAMINATION METHOD:

□ On Site following Course
□ Computerized Version at PSI Testing Centers

11. ADA ACCOMMODATIONS

□ YES, special arrangements will be necessary for me to complete the examination. (If yes, complete forms in handbook and submit to NAWCO)

12. APPLICATION-CERTIFICATION FEES

☑ Non-Refundable Processing Fee. $30.00
☐ Certification Fee $300.00
☐ Lapsed Late Fee $300.00

Balance Due: _____

13. WORK EXPERIENCE VERIFICATION: All candidates must complete the following section(s) to document required wound care related work experience. Missing or incomplete information **will** cause delay in processing. Misrepresentation discovered pre or post certification may result in denial or revocation of credential.

Employer_____

Employer Full Address_____

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

Supervisor Name: _____ Supervisor Phone #: _____

P O Box 235 Somonauk IL 60552 P: 877-922-6292 F: 800-352-8339

Employer_____

Employer Full Address_____

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

Supervisor Name: _____ Supervisor Phone #: _____

14. Agreement Authorization and Certification Information Release

I hereby affirm that I have been a _____ actively and directly involved in the delivery of wound care or in Management, Education or Research directly related to wound care for a: (Please check one)

□ LESS than two years full-time or four years part-time within the past five years. (PRECEPTOR OPTION)
□ MINIMUM of two years full-time or four years part-time within the past five years.

I further affirm that I am currently licensed to practice as a _____ (License Type) 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® WCC® Certification Directory, in print and electronic versions of a worldwide directory of NAWCO® WCC® 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 WCC® 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 WCC® 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.

I affirm that it is my responsibility to obtain an approved clinical preceptor and I am responsible for all associated fees. I also am aware I must complete my clinical hours within one year of the approved skin and wound management course and that I may not begin my clinical hours until I have completed that course. **(Preceptor Option Only - Initial only if applicable)** Initial _____

By signing this agreement, I hereby swear and attest to all the contents of the Candidate Agreement/Statement of Understanding contained within the NAWCO® WCC® 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.

I have read and agree to abide by the NAWCO® Code of Ethics listed in the WCC Candidate Handbook.

_____ _____

Applicant's Signature Today's Date

15. PAYMENT: CREDIT CARD AUTHORIZATION FORM: Complete this section ONLY if paying by Credit Card

Explanation of Fees:

☑ **Non-Refundable Processing Fee. $30.00**

Certification Fee $300.00

Lapsed Late Fee (If Applicable) $300.00

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

❑ 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_____

Email: _____ Telephone: _____

Cardholder Signature: _____ Date: _____

National Alliance of Wound Care and Ostomy®

P O Box 235 Somonauk IL 60552 P: 877-922-6292 F: 800-352-8339