SAMPLE

Documentation Form for CRNO Recertification through Continuing Education

Directions: To recertify through continuing education, the candidate must document 75 contact hours (CH) of continuing education. A minimum of 60 contact hours must be in varied areas of I –IV of the content outline: (I) Ocular Conditions, (II) Pharmacology, (III) Nursing Assessment of the Ophthalmic Patient, (IV) Ophthalmic Nursing Interventions and Patient Education. An individual may accumulate a maximum of 5 contact hours for teaching ophthalmology-specific courses; 1 hour per presentation. The remaining 15 contact hours may be in academic courses or Section (V) of the content outline-Professional Issues. All applicable contact hours must have been completed during the five years preceding the candidate's certification renewal date. Contact hours may be accumulated in any combination of (A) continuing education programs, and (B) academic courses. All CRNO's are responsible for maintaining continuing education records used for this Application. All Applications are subject to audit and may be randomly selected for verification of the information provided. Candidates whose Applications are selected for audit will be notified on receipt of Application and will be requested to document all entries.

A. CONTINUING EDUCATION PROGRAMS (These may include workshops, seminars, professional development offerings, home-study courses, and state or national conferences approved or provided by an ANCC accredited organization, a SNA, a BRN accredited Registered Nurse or Registered Nurse organization provider, or an ACCME accredited organization (see accreditation definitions on in Guidelines for Recertification document). Candidates must have written documentation of the number of hours for each program completed. List programs in date order, beginning with the most recent. Print or type all information.) ACLS, BCLS, PALS and CPR courses are not acceptable for recertification. Please review sample form carefully before completing.

Mo/Yr of Program	Program Title	Program Code *	Full Name of Program Provider	Accreditation Type	Numbers of Hours
6/03	ASORN Regional Meeting	C	American Society of Ophthalmic Registered Nurses	ANCC	7.5
10/02	AAO Annual Meeting	C	American Academy of Ophthalmology	ACCME	10.0
12/01	Refractive Surgery Overview	H	ASORN/Journal: Insight	ANCC	1.2
9/01	Ophthalmic Update 2001	C	Grand Canyon Chapter of ASORN	AZ-SNA	8.0
9/01	Macular Degeneration	S	Grand Canyon Chapter of ASORN	N/A	1.0
6/01	Ophthalmology Review	C	Bay Area Local Chapter of ASORN	CA- BRN	6.5

* Program Code: **W** = Workshop/Seminar **C** = State/National Conferences **H** = Homestudy/Correspondence **I** = Internet **S = Speaker** **O** = Other

List additional programs on separate sheet of paper, if needed, for 75 hours.
Enclose with but do not staple to Application.

ENTER TOTAL NUMBER OF CONTACT HOURS: _____

CONTINUE ON PAGE 4

SAMPLE CONTINUED

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B. ACADEMIC COURSES (Each individual academic credit will be considered as ten (10) contact hours and may be at undergraduate or graduate level. A maximum of 15 contact hours will be eligible. A transcript of successful course completion must be available, if audited. List courses in date order, beginning with the most recent. **Print** or **type** all information.)

Month/Year Completed	Institution (Name & State)	Course Title	Course Credits	Equivalent Contact Hours (Credit x 10)
May 2002	University of California, Davis	Healthcare Administration	3	30

ENTER TOTAL NUMBER OF EQUIVALENT CONTACT HOURS FROM ACADEMIC COURSES (maximum 15): 15

C. Before signing Candidate Affirmation, PRINT your name exactly as it appears on your current CRNO Certificate:

_____

Name (PRINT)

ENTER TOTAL CONTACT HOURS HERE AND IN THE BOXES INDICATED ON PAGE 1, ROUNDING TO THE NEAREST WHOLE NUMBER.

D. CANDIDATE AFFIRMATION/AUTHORIZATION

I affirm that all statements given on this Application are true and correct to the best of my knowledge and that the NCBORN is hereby authorized to contact any organization or individual listed hereon to verify my continuing education history.

_____

SIGNATURE Date

_____

Current RN License Number State

Mail completed application form and documentation form along with the appropriate fee to:

NCBORN Recertification Processing
Professional Testing Corporation
1350 Broadway, 17th Floor
New York, NY 10018