

Application for Certification Reciprocity for Nurse Life Care Planners



Background Information

H. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN CERTIFIED AS A CNLCP?

- No
- Yes, currently certified. Certification expires (indicate year): _____
- Yes, previously certified by certification. Lapsed on (indicate month/year): _____/_____/_____

I. ORGANIZATIONS TO WHICH YOU BELONG:

(Select all that apply)

- American Nurses Association
- Amer. Assoc. of Legal Nurse Consultants
- Case Management Society of America
- Association of Rehabilitation Nurses
- Sigma Theta Tau
- National Institute of Case Managers
- International Association of Rehabilitation Professionals /International Academy of Life Care Planners

J. HAVE YOU RECEIVED CERTIFICATION THROUGH RECIPROcity BEFORE?

- No Yes

If yes, indicate month, year, and name under which reciprocity was given.

Date (month/year): _____

Name: _____

K. YEARS OF WORK EXPERIENCE AS AN RN:

- 5 years 9 to 12 years
- 6 to 8 years Over 12 years

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your certification.

Race:

- African American Native American
- Asian White
- Hispanic Other

Age Range:

- Under 25 40 to 49
- 25 to 29 50 to 59
- 30 to 39 60+

Gender:

- Male
- Female

Work Experience

Supervisor Name (please print)	Institution/Organization	Address
Title	City, State, Zip	Phone

Supervisor Name (please print)	Institution/Organization	Address
Title	City, State, Zip	Phone

Candidate Signature

I have read the Handbook for Candidates and understand that I am responsible for knowing its contents. I certify that the information given in this Application is in accordance with Handbook instructions and is accurate, correct, and complete. Information on a candidate's initial certification date, renewal dates, and any CNLCP suspensions or revocation of CNLCP will be released by the CNLCP® Certification Board upon request to any public entity or agency. By signing this Application, I am providing authorization for release of this information and for the use of aggregate data. Personal information outside of CNLCP status will not be accessed and/or released without my approval.

CANDIDATE SIGNATURE: _____ **DATE:** _____

CREDIT CARD PAYMENT *If you want to charge your application fee on your credit card provide all of the following information.*

Name (as it appears on your card): _____

Address (as it appears on your statement): _____

Charge my credit card for the total fee of: \$ _____

Expiration date (month/year): _____ / _____

Card type: Visa MasterCard American Express

Card Number: _____

SIGNATURE: _____

FOR OFFICE USE ONLY

Date _____ 0840

Date

Fee: _____

CC Check

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