2022 HPCC EXAMINATION APPLICATION

To apply online, visit advancingexpertcare.org/certification.

To apply using this form, provide the requested information and mail it to be **RECEIVED** by PSI by the paper application deadline. Applications received after the deadline or postmarked on the deadline will be returned unprocessed. **FAXED APPLICATIONS ARE NOT ACCEPTED.** Read the Candidate Handbook before completing this application. Mail the completed application and payment made by credit card, personal check, cashier's check or money order payable to PSI Services Inc. to: HPCC Certification Examination, PSI, 18000 W. 105th St., Olathe, KS 66061-7543.

1. Personal Information (please print using blue or black ink)

Last Name:

First Name: Middle Initial:

Former Name *(if applicable)*:

Date of Birth (xx/xx/xxxx):

Applicant Email Address:

Your HOME Information

Address Line 1:

Address Line 2:

City:

State/Province: Zip/Postal Code:

Country:

Home Phone: Cell Phone:

2. I am a:

- ☐ New Applicant (not currently certified at this level)
- ☐ Reapplicant (previously attempted this examination and have not previously held this certification)
- ☐ Applicant for Renewal (currently certified at this level) ***Renewal by exam is available for only CHPLN and CHPNA.***
- ☐ reTEST Assured Applicant (previously attempted this examination after March 1, 2022 and did not pass. Applying to test in one of the next three windows following my unsuccessful attempt.) *Do not submit the reTEST Assured application until you are ready to test.*

☐ I am including a Special Examination Accommodations Request. Please include completed form at end of handbook.

3. Eligibility and Examination Fees

Persons applying for a certification examination who are current HPNA members **PRIOR** to applying for the Certification Examination are entitled to the HPNA member discounted examination fee as a membership benefit. Must include HPNA membership to receive discount.

HPNA membership number _____

HPCC certification number (for renewal) _____

	Initial Certification		Renewal of Certification		reTEST Assured
	HPNA Member	Non-HPNA Member	HPNA Member	Non-HPNA Member	All Applicants
Advanced Practice Registered Nurse Examination	☐ $320	☐ $465	Refer to Page 12	Refer to Page 12	☐ $125
Registered Nurse Examination	☐ $285	☐ $415	Refer to Page 11	Refer to Page 11	☐ $125
Pediatric Registered Nurse Examination	☐ $285	☐ $415	Refer to Page 11	Refer to Page 11	☐ $125
Licensed Practical/Vocational Nurse Examination	☐ $240	☐ $345	☐ $205	☐ $320	☐ $125
Nursing Assistant Examination	☐ $175	☐ $225	☐ $150	☐ $200	☐ $125

Payment Information: Please indicate your method of payment.

- ☐ Check or money order (personal or cashier's check payable to PSI Services Inc.)
- ☐ Credit card: If payment is made by credit card, please provide the following information.
- ☐ MasterCard ☐ VISA ☐ AMEX ☐ Discover

Account Number Expiration Date (MO/YR) Security Code

Name as it Appears on Card Signature

Demographic Information – *Please complete the following demographic questions. Select only one response for each question, unless directed otherwise.*

1. Which best describes the nature of your practice?
   - [1] Hospice
   - [2] Palliative
   - [3] Both

2. Total number of years in your profession:
   - [1] 0-2 years
   - [2] 3-5 years
   - [3] 6-10 years
   - [4] 11-15 years
   - [5] 16-20 years
   - [6] 21-25 years
   - [7] 26-30 years
   - [8] More than 30 years

3. Total number of years in hospice and palliative care:
   - [1] 0-2 years
   - [2] 3-5 years
   - [3] 6-10 years
   - [4] 11-15 years
   - [5] 16-20 years
   - [6] 21-25 years
   - [7] 26-30 years
   - [8] More than 30 years

4. Which of the following is your primary employer? (check one)
   - [1] Hospice facility
   - [2] Home healthcare agency
   - [3] Hospital or acute care facility
   - [4] Long-term care facility
   - [5] Academic institution
   - [6] Self (private practice)
   - [7] Private physician practice
   - [8] Correctional facility
   - [9] Ambulatory care/out patient care facility
   - [10] Government (fed, state, military, VA, NIH, etc.)
   - [11] Association/non-profit
   - [12] Private or public company

5. What is your practice setting?
   - [1] Non-hospice – community-based clinical
   - [2] Non-hospice – acute care facility
   - [3] Palliative – acute care facility
   - [4] Palliative – community-based clinical
   - [5] Hospice – acute care facility
   - [6] Hospice – community-based clinical
   - [7] Academic or research setting
   - [8] I do not see patients

6. What best describes your practice?
   - [1] Administrative
   - [2] Clinical
   - [3] Education
   - [4] Research

7. What best describes your current occupation?
   - [1] Allied Therapist
   - [2] Chaplain
   - [3] Child Life Specialist
   - [4] Clinical Nurse Specialist
   - [5] Counselor
   - [6] LPN/LVN
   - [7] Nurse Practitioner
   - [8] Nursing Assistant
   - [9] Physician
   - [10] Psychologist
   - [11] Registered Nurse
   - [12] Social worker

8. What is the highest academic level you have attained?
   - [1] High school
   - [2] Nursing assistant education program
   - [3] Nursing diploma from an accredited nursing school/program
   - [4] Associate degree in nursing
   - [5] Bachelor's degree (nursing)
   - [6] Bachelor's degree (non-nursing)
   - [7] Master's degree (nursing)
   - [8] Master's degree (non-nursing)
   - [9] Doctoral degree (nursing)
   - [10] Doctoral degree (non-nursing)

9. Primary age group served:
   - [1] Adult
   - [2] Pediatric
   - [3] Both

10. Gender:
    - [M] Male
    - [F] Female
    - [T] Transgender
    - [O] Other
    - [N] Prefer not to disclose

11. Your Race:
    - [1] Black or African American
    - [2] American Indian or Alaska Native
    - [3] White or Caucasian
    - [4] Asian
    - [5] Native Hawaiian or other Pacific Islander
    - [6] Other
    - [7] Choose not to identify

12. Your Ethnicity:
    - [1] Hispanic or Latino
    - [2] Not Hispanic or Latino

13. Credentials: _____
    _____

14. Employer Name (required): *If you are not currently employed, please enter 'none.'* _____
    _____
    _____

15. Employer Street Address: _____
    _____
    _____

16. City: _____

17. State: _____

18. Zip Code: _____

19. Employment Status:
    - [1] Full time employee
    - [2] Part time employee
    - [3] Self employed
    - [4] Not employed/seeking

20. Primary facility location?
    - [1] Rural
    - [2] Suburban
    - [3] Urban

21. What is your primary license?
    - [1] Certified nursing assistant
    - [2] Licensed practical/vocational nurse
    - [3] Physician
    - [4] Affiliated profession (Social Worker, Counselor, Child Life Specialist, Chaplain)
    - [5] Advanced Practice Registered Nurse (CNM, CNS, CRNA, CNP)
    - [6] Registered nurse
    - [7] Psychologist
    - [8] Not licensed/does not apply

22. If you selected Advanced Practice Registered Nurse, please indicate the type:
    - [1] Certified Nurse Midwife (CNM)
    - [2] Clinical nurse specialist (CNS)
    - [3] Certified registered nurse anesthetist (CRNA)
    - [4] Certified nurse practitioner (CNP)

Attestation and Signature (*Check each box to attest to your agreement to the statements below.*)

☐ I certify that I have read all portions of the Candidate Handbook and application, and I agree to all terms of the HPCC processing agreement. I certify that the information I have submitted in this application and the documents I have enclosed are complete and correct to the best of my knowledge and belief. I understand that, if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed or voided, not released or invalidated by HPCC.

Non-disclosure of Exam Content

☐ Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except HPCC. Per HPCC policy, sharing of exam content is cause for revocation of certification. I certify that I have read that all examination questions are the copyrighted property of HPCC and it is forbidden under federal copyright law to copy, reproduce, record, distribute, or display the examination questions by any means, in whole or in part. Doing so may subject me to severe civil and criminal penalties.

Ethics

☐ I understand the importance of ethical standards and agree to act in a manner congruent with the HPNA Code of Ethics for Nurses.

Attestation and Signature (*Your signature in ink attests to your agreement to the above statements.*)

Name (Please Print) Signature Date

Audits of HPCC Applications – To ensure the integrity of eligibility requirements, HPCC will audit a percentage of randomly selected applications each year. Candidates whose applications are selected for audit will be notified and required to provide documentation of their professional license and verification of practice hours.

Please check below to confirm you currently meet the eligibility requirements for the examination you are registering for:

Advanced Practice Registered Nurse Examination

☐ I am currently licensed as an APRN in the United States, its territories or the equivalent in Canada.
☐ Nurse Practitioner ☐ Clinical Nurse Specialist
Mail a copy of your APRN license to: HPCC Certification Examination APRN License, PSI, 18000 W. 105th St., Olathe, KS 66061-7543.

☐ Licensure: State_____ APRN License Number _____ APRN License Expiration _____

☐ I have worked as an advanced practice registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

☐ Completion of an accredited graduate, postgraduate, or doctoral Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) educational program from a U.S. school or Canadian province NP or CNS educational programs approved by the Canadian Council of Registered Nurse Regulators (CCRNR).

☐ Completion of three separate comprehensive graduate-level courses in advanced pathophysiology, advanced health assessment, and advanced pharmacology.

Registered Nurse Examination

☐ I am currently licensed as a registered nurse in the United States, its territories or the equivalent in Canada.

☐ Licensure: State_____ RN License Number _____ RN License Expiration_____

☐ I have worked as a registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

Pediatric Registered Nurse Examination

☐ I am currently licensed as a registered nurse in the United States, its territories or the equivalent in Canada.

☐ Licensure: State_____ RN License Number _____ RN License Expiration_____

☐ I have worked as a pediatric registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

Licensed Practical/Vocational Nurse Examination

☐ I am currently licensed as a licensed practical/vocational nurse in the United States or its territories.

☐ Licensure: State_____ LPN/LVN License Number _____ LPN/LVN License Expiration_____

☐ I have worked as a licensed practical/vocational nurse under the supervision of a registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

Nursing Assistant Examination

☐ I have worked as a nursing assistant under the supervision of a registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

Within the last five (5) years:

Yes	No	
☐	☐	Have you ever been sued by a patient?
☐	☐	Have you ever been found to have committed negligence or malpractice in your professional work?
☐	☐	Have you ever had a complaint filed against you before a governmental regulatory board or professional organization?
☐	☐	Have you ever been subject to discipline, certificate or license revocation, or other sanction by a governmental regulatory board or professional organization?
☐	☐	Have you ever been the subject of an investigation by law enforcement?
☐	☐	Have you ever been convicted of, pled guilty to, or pled nolo contendere to a felony or misdemeanor, or are any such charges pending against you?

I further affirm that no licensing authority has taken any disciplinary action in relation to my license to practice in the aforementioned or any other state, and that my license to practice has not been suspended or revoked by any state or jurisdiction.

I understand that no refunds will be issued once payment is processed.

Name (Please Print) Signature Date

Practice Verification: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name (Last) (First) Facility Name

Verifier's Phone Number Verifier's Email Address

You may not list yourself or a relative as your verifier.

HPCC reserves the right to contact you for further information as deemed necessary.