



AMERICAN BOARD FOR OCCUPATIONAL HEALTH NURSES, INC.

7250 W. College Dr., #2SW, Palos Heights, IL 60463

www.abohn.org

APPLICATION FOR EXAMINATION / DO NOT FAX

All information provided on this application will be treated with strict confidence.

ABOHN's policy is that no individual shall be excluded from the opportunity to participate in the ABOHN credentialing program on the basis of race, national origin, religion, gender, age or disability.

PLEASE TYPE OR PRINT YOUR APPLICATION! Each item on this form must have a response. If **"none" or "no" is applicable, so state.** Incomplete responses will result in delay and possible disqualification. Applications must include the application fee. Please consult the examination handbook for application completion instructions.

1. WHICH EXAMINATION DO YOU WISH TO TAKE? COHN COHN-S

2. HAVE YOU APPLIED FOR AN EXAM WITH ABOHN BEFORE? YES NO

3. HAVE YOU TAKEN AN EXAM WITH ABOHN BEFORE? YES NO

4. NAME

First _____

Middle _____

Last _____

Maiden Name _____

Other Last Names Used _____

5. YEAR OF BIRTH _____

6. EMAIL PREFERRED (mandatory) _____

ABOHN corresponds via the preferred email address. It is the credential holder's responsibility to ensure that ABOHN has the current, preferred email.

ALTERNATE EMAIL (non-mandatory) _____

7. HOME ADDRESS Street _____ Apt/Unit _____

City _____ State _____ Zip _____

Country _____

Telephone () _____

8. CURRENT EMPLOYER _____

Street _____

City _____ State _____ Zip _____

Country _____

Telephone () _____ FAX () _____

9. SALARY (for group analysis use only) *Part-time: hours per week* _____ *Hourly Rate \$* _____
 Full Time: Annual Salary \$ _____

10. BUSINESS CATEGORY OF EMPLOYMENT (See Business Codes on page 7) Code _____

11. JOB TITLE (See Job Title Codes on page 8 to select the appropriate title.) Code _____

12. PUBLISHED IN ONLINE DIRECTORY: **YES** **NO**

ABOHN's online directory is only available for use by credential holders that are considered in ACTIVE status. This directory is helpful to other certified OHNs to locate other verified credential holders. ABOHN publishes only your name, home city, home state, home country and preferred email.

13. EDUCATION (Check ALL education you have completed.)

- 1. ASSOCIATE DEGREE**
- 2. DIPLOMA**
- 3. BACCALAUREATE IN NURSING**
- 4. OTHER BACCALAUREATE**
- 5. MASTER'S IN NURSING**
- 6. MASTER'S IN PUBLIC HEALTH**
- 7. OTHER MASTER'S**
- 8. DOCTORATE**

14. PROFESSIONAL MEMBERSHIPS Check those professional organizations in which you hold membership.

- AAOHN** (*American Association of Occupational Health Nurses*)
- AIHA** (*American Industrial Hygiene Association*)
- ANA** (*American Nurses Association*)
- AOHP** (*Assoc. of Occupational Health Professionals in Healthcare*)
- ASSE** (*American Association of Safety Engineers*)
- CMSA** (*Case Management Society of America*)
- CNA** (*Canadian Nurses Association*)
- Other** _____

15. OTHER CERTIFICATIONS HELD Check those professional certifications you currently hold.

- CCHEST-OHST** (*Occupational Health and Safety Technologist*)
- CCM** (*Certified Case Manager*)
- CHMM** (*Certified Hazardous Materials Manager*)
- CIH** (*Certified Industrial Hygienist*)
- COHC** (*Certified Occupational Hearing Conservationist*)
- COHN-C** (*Certified Occupational Health Nurse - Canada*)
- CSP** (*Certified Safety Professional*)
- NP** (*Nurse Practitioner*)
- Other** _____

16. EXPERIENCE IN OCCUPATIONAL HEALTH NURSING

During the 5-year period prior to application, you must have earned 3,000 hours of work (occupational health nursing) experience. Full time employment for one year equals 2,080 hours. Refer to your Candidate Handbook for alternatives to work experience. Begin with your most recent or current position. Reproduce this page if you have held more than one job during the five-year time period. List occupational health nursing work experience in the past 5 years only.

POSITION #

DATES EMPLOYED	from		to	

TOTAL SERVICE	Years		Months		Total hours	
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POSITION TITLE

Briefly describe job responsibilities in this position and the target population to which you provide occupational health nursing care. SEND A COPY OF YOUR CURRENT JOB DESCRIPTION WITH THIS APPLICATION.

NAME OF EMPLOYER	
Address	
Major Product/Service	

PERSON WHO CAN VERIFY YOUR EMPLOYMENT

Name	
Title	
Telephone #	
E-mail address	

17. WHERE DID YOU INITIALLY LEARN ABOUT ABOHN CERTIFICATON?

(Check one only)

- AAOHN National Conference**
- AAOHN Publication**
- AOHC** *(American Occupational Health Conference)*
- AOHP** *(Association of Occupational Health Professionals)*
- CMSA Conference** *(Case Management Society of America)*
- Occupational Health & Safety Publication**
- Other** _____

18. Name of certified Occupational Health Nurse who referred you to sit for the certification examination:

19. EXAMINATION ACCOMMODATION

YES **NO**

Any request for special examination accommodations pursuant to the Americans with Disabilities Act must be made in writing. Please submit via fax or email, the Request for Special Examination Accommodations form found in the back of the examination handbook. Upon receipt of the request of special accommodations, ABOHN will contact you to determine the nature of accommodations required.

20. AUTHORIZATION TO ABOHN

I authorize the American Board for Occupational Health Nurses, Inc. (ABOHN) to request information concerning me from any of the persons or organizations referred to in this application for Board certification.

I hereby attest that all of the information contained in this application, including any documents that I have submitted, is true and correct to the best of my knowledge. I acknowledge that the ABOHN certification program is entirely voluntary and agree to be bound by ABOHN’s policies and procedures, as they now exist or as they may be amended in the future. I understand that any falsification in this application will be grounds for rejection or revocation of any certification issued.

Once certified, I agree to pay all non-refundable fees and meet such standards as required by ABOHN to maintain certification status and, if selected above, to be listed in the directory of certified occupational health nursing by the **American Board for Occupational Health Nurses, Inc.**

Yes No

Signature: _____ *Date:* _____

Remember before mailing this application:

- **Please make a copy of this application for your records**
- **Enclose non-refundable application fee**

Please include copies of:

- **RN license**
- **Current job description**
- **Advanced education, final transcripts and/or certificate from a NIOSH ERC program.**

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