ANCC proudly offers certification for

Clinical Nurse Specialist in Pediatrics

eligibility criteria

- Hold a current, active RN license in a state or territory of the United States or the professional, legally recognized equivalent in another country.
- Hold a master's, post-master's, or doctorate from a clinical nurse specialist in a pediatrics program or a program that provides course work that addresses children's unique physiological, psychological, and developmental needs from birth through age 21 that is accredited by the Commission on the Collegiate of Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC).
- A minimum of 500 faculty supervised clinical hours in the Pediatric CNS role and specialty must be included in the educational program. This Pediatric CNS graduate program must include three separate courses in:
  - advanced health assessment
  - advanced pharmacology
  - advanced pathophysiology

All requirements must be completed prior to application for the examination. An incomplete application affects a candidate's ability to test.

For more information: **www.nursecredentialing.org**

Testing Information

Clinical Nurse Specialist in Pediatrics

Overview of test content outline

For full test content outline, go to **www.nursecredentialing.org**

I. Developmental/Behavioral Sciences (see Note 1)

A. Psychosocial/cognitive development
B. Physical development
C. Family concepts and issues
D. Cultural/spiritual diversity
E. Behavior modification

II. Communication

A. Therapeutic, written, professional
B. Confidentiality, HIPPA

III. Nursing Process (see Note 1)

A. Physical/psychosocial assessment of patient/family
B. Nursing diagnosis, outcome identification
D. Planning, implementation, evaluation

IV. Basic and Applied Science (see Note 1)

A. Trauma and disease processes
B. Pharmacology, nutrition
C. Chemistry

V. Educational Principles and Strategies

A. Teaching and learning principles, methodology
B. Educational outcomes and evaluations

VI. Life Situations and Adaptive/Maladaptive Responses

A. End of life/death & dying
B. Crisis concepts & interventions
C. Substance abuse
D. Psychological responses
E. Child maltreatment

VII. Health Maintenance, Promotion, and Wellness

A. Immunizations
B. Anticipatory guidance/patient safety
C. Community-based screenings and resources
D. Barriers to care

VIII. Management/Leadership

A. Quality improvement
B. Management principles, organizational structure
C. Professional development

IX. Research

A. Process & utilization
B. Evidence-based nursing practice

X. Legal and Ethical Issues

A. Guidelines
B. Reimbursement
C. Authority for decision-making

Notes

Note 1: Acute & Chronic Major Health Problems

1. Musculoskeletal/neuromuscular
2. Cardiovascular/respiratory
3. Sensory
4. Gastrointestinal
5. Genitourinary
6. Integumentary
7. Endocrine
8. Hematologic/immunologic
9. Psychosocial

Testing Information

Clinical Nurse Specialist in Pediatrics

2008-2010 Application Fees

Prices below include $140 non-refundable administrative fee

ANA Member	$270	Required attachment: A copy of your American Nurses Association membership card (Full and Direct ANA members only. Individual Affiliate members excluded from this offer.)
Discount	$340	Discount $340 Required attachment: A copy of your National Association of Clinical Nurse Specialists membership card
Non-Member	$390	
Additional Special Fees:		
International Testing	$125	See **www.nursecredentialing.org** for details.

Preparing for the Exam

This exam is a computer-based test. This means you can apply all year and test during a 90-day window at a time and location convenient to you. Applications for this certification will be accepted at any time.

Detailed information about the application and testing process, withdrawing an application, ineligible to test, and other frequently asked questions is in the General Testing and Renewal Handbook available at **www.nursecredentialing.org** From this website, you can type into, save, and print your application. Please sign, attach required documents, and mail the complete application. ANCC will review it to determine whether your application meets eligibility criteria.

Information to prepare for the exam, such as review courses, detailed test content outline, references, and sample questions, is available at **www.nursecredentialing.org** or call our Customer Care Center at 1.800.284.2378.

If you require a verification of exam eligibility and/or certification, visit **www.nursecredentialing.org** or call 1.800.284.2378.

Mailing Instructions

Print legibly using either black or blue ink. **Keep a photocopy of your application for your records.** Submit an application, copy of RN license (if your board of nursing issues a paper license), and payment. Remember to attach all required supporting documents and mail to:

American Nurses Credentialing Center
P.O. Box 791333
Baltimore, MD 21279-1333

Staff use only: ☐ E ☐ P ☐ NE

CNSPED10 WEB 12/09

ANCC Certification Application Form

Clinical Nurse Specialist in Pediatrics

General Information 1

Use your legal name on the application. This name must match photo identification used for examination entry and will be the name printed on your certificate.

Last Name | First Name | MI

Maiden or Other Past Legal Names | Social Security Number

Home Address

City | State | Zip/Postal | Country

Home Phone | Home Fax | Personal E-Mail

Employer Name

Employer Address

City | State | Zip/Postal | Country

Work Phone | Work Fax | Work E-Mail

Type of primary position:

☐ Nurse Manager
☐ Nurse Practitioner
☐ Administrator/DON/CNO/VP Nursing
☐ Associate/Assistant Administrator
☐ Educator
☐ Researcher
☐ Clinical/Staff Nurse
☐ Clinical Nurse Specialist
☐ Consultant
☐ Other: ____________________

Payment 2

☐ Personal Check/Money Order (payable to ANCC)
☐ Charge Card (MasterCard or VISA only)
☐ Check here if this is an ATM/Debit card. See authorization below.*

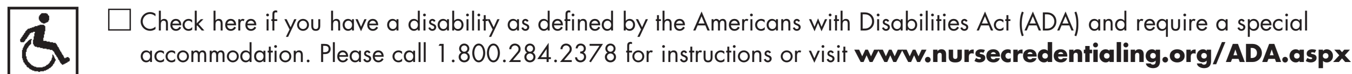
Amount Enclosed: ____________________
Amount to be charged: ____________________
Promotional Code (if applicable): ____________________

Account Number | Exp. Date

Print Name on Card | Signature

* *ATM/Debit Card users only:* I understand and agree that, by using an ATM/Debit card, I am authorizing ANCC to debit my account for the amount specified above. Further, I understand and agree that, if the ATM/Debit transaction fails or is declined, I am authorizing ANCC to complete the transaction as a credit card charge, if possible.

Special Accommodations/Americans with Disabilities Act 3



☐ Check here if you have a disability as defined by the Americans with Disabilities Act (ADA) and require a special accommodation. Please call 1.800.284.2378 for instructions or visit **www.nursecredentialing.org/ADA.aspx**

Validation of Clinical Nurse Specialist Education Program

INSTRUCTIONS Allow sufficient time for the **program director to complete and return the original form** to you for inclusion with your application. Only the original document including the original signature and dates is accepted. (A photocopy or faxed document is not accepted). Only forms received within one-year of the program director's signature are accepted.

Applications received with outdated or incomplete forms will delay the review process and impact your ability to take the exam.

The current program director completes items 1-10 and returns the original form to the candidate to include with your application.

Please type or print all information.

____

Candidate's Name (Last, First, MI) Social Security Number

1. The individual named above graduated from:

____

Name of University/School

____

School Code (Available at **www.nursecredentialing/cert/school codes.cfm**) This allows ANCC to provide an aggregate data report.

Designate the organization(s) which accredit(s) your program:

☐ Commission on Collegiate Nursing Education (CCNE) ☐ National League for Nursing Accrediting Commission (NLNAC)

____

Program Name (e.g. CNS in Adult Health)

____

Program Address

____

Program Telephone Number

2. Date candidate completed this graduate program: ______________________

Did this candidate complete a dual program? ☐ No ☐ Yes, If yes, then specify the role and specialty completed. Also, provide a detailed description of the content for each role and specialty completed by the candidate.

____

____

____

3. Check the type of program and date degree conferred:

a. ☐ Master's in Nursing conferred on ________________________

b. ☐ Doctorate in Nursing conferred on ________________________

c. ☐ Post-Graduate Certificate in nursing completed on ________________________

Required Attachment: Provide a detailed description of the courses and clinical hours accepted from previous graduate program(s) and list all courses and clinical hours in the post-graduate certificate program that support eligibility.

4. Check the one CNS area of concentration completed:

☐ Adult Health Clinical Nurse Specialist
☐ Adult Psychiatric & Mental Health Clinical Nurse Specialist
☐ Child/Adolescent Psychiatric & Mental Health Clinical Nurse Specialist
☐ Gerontological Clinical Nurse Specialist
☐ Pediatric Clinical Nurse Specialist

Continued on next page

Validation of Clinical Nurse Specialist Education Program

5. Indicate the separate course number(s) and course title(s) for graduate content for:

Advanced Health Assessment

____

Advanced Pharmacology

____

Advanced Pathophysiology

____

6. Write the course number(s) and title(s) for the following graduate content.

CNS Role

____

CNS Specialty Clinical/Practicum

____

7. Total number of CNS didactic credits: __________

8. TOTAL Faculty supervised clinical hours: __________

A. CNS ROLE: Write the exact number of faculty supervised clinical hours completed by this candidate in the **CNS role and population** identified in item 6. ______________

B. DUAL APRN PROGRAMS: Write the exact number of faculty supervised clinical hours completed by this candidate for the entire program. ______________

C. POST-GRADUATE PROGRAM: Write the exact number of faculty supervised clinical hours completed by this candidate for the post-graduate certificate. ______________

D. PREVIOUS GRADUATE PROGRAM: Write the exact number of faculty supervised clinical hours accepted from your previous graduate program as described in item 3. ______________

9. For Psychiatric-Mental Health CNS Specialty Only (The candidate must complete at least 2 modalities)

Please check the psychotherapeutic treatment modalities in which the candidate received supervised clinical training at the graduate or post graduate level and indicate the course name and course number:

Psychotherapeutic Treatment Modalities	Course(s) Title and Number
☐ Individual	______________________
☐ Group	______________________
☐ Family	______________________
☐ Expressive Therapies	______________________
☐ Milieu	______________________
☐ Play Therapy	______________________
☐ Other	______________________

10. Program Director Signature Your signature on this form attests that the above named individual completed the graduate nursing education program as indicated on this document and completed all course work as stated on this form. Completion of this information does not to convey approval of a school program or eligibility for a candidate to test. Confirm your school code in item 1 to facilitate ANCC providing your annual aggregate data report.

____

Program Director (Print Name)

____

Program Director's Signature Date

Education 5

Check all that apply:

- ☐ Diploma
- ☐ Associate Degree in Nursing
- ☐ Associate Degree in Other Field
- ☐ Baccalaureate in Nursing
- ☐ Baccalaureate in Other Field
- ☐ Master's in Nursing
- ☐ Master's in Other Field
- ☐ PhD in Nursing
- ☐ PhD in Other Field
- ☐ EdD
- ☐ DNP
- ☐ DNSc
- ☐ ND
- ☐ Other: ______________________

Please list all degrees you have been awarded with the most recent degree first (do not include high school). Attach additional page if necessary.
Required attachment: All official advanced degree transcripts. The following are not accepted: photocopies, faxes, attached transcripts that are not in a sealed envelope from the school.

School Name ______ School Code ______

Major/Area of Study ______ Date and Degree Conferred ______

School Name ______ School Code ______

Major/Area of Study ______ Date and Degree Conferred ______

School codes:
Available on-line at **www.nursecredentialing.org/certapp/schoolcodes.cfm**

Check one of the following:

- ☐ I have requested my school send transcripts directly to ANCC.
- ☐ I have obtained transcripts in a sealed envelop directly from my school and have attached these transcripts to this application.

Licensure Information 6

All candidates must complete this section in its entirety.

Required attachment: Attach a copy of license ☐ Check this box if your state does not issue a paper license

☐ Check this box if your RN license is not from a state or territory of the United States

Current RN License Number ______

State/Country ______ Expiration Date (month/date/year) ______

Statement of Understanding 7

I hereby apply for certification offered by the American Nurses Credentialing Center (ANCC). I have read the eligibility criteria for certification. I understand that I am subject to all eligibility requirements for certification as described in this application and that eligibility for certification depends on successfully completing specified certification program requirements. If certified, my name will be included in the official listing of certified nurses.

By signing below, I authorize ANCC staff and the Commission on Certification to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to verify my credentials, education preparation, practice, professional standing, and any other information included in, submitted with, or necessary for review of this application.

I expressly acknowledge and agree that information accumulated by ANCC through the certification process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to schools or external researchers. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without my permission.

I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature, that I will maintain an active registered nurse license throughout the entire certification period, including all renewal periods. I understand that any misstatement of material fact submitted on, with, or in furtherance of this application for certification shall be sufficient cause for ANCC to: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; withhold this or other ANCC certifications; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

I further understand that if my certification record is audited, I will be required to submit documentation to support the information in my application. I further understand that if I fail to timely submit supporting documentation, ANCC can: bar me from taking this and future ANCC certification examinations; invalidate the results of my examination; revoke this or other ANCC certifications; and take other action against me, including but not limited to notifying licensing authorities, law enforcement agencies, and employers.

(Applications received without a signature incur a delay in processing which will cause a delay in the review of your application and ability to take a certification examination.)

Required Signature ______ Print Name ______ Date ______

MAILING LIST REFUSAL

ANCC may release mailing lists from its certification database to organizations or individuals who have information to distribute that would be beneficial to nurses or to nursing and credentialing research. If you do not wish your name and mailing address to be released for marketing purposes, please mark the decline option below.

☐ I do not wish my name and mailing address to be released for any marketing purposes.

Demographic and Employment Information 8

1. Location of facility:
- ☐ Urban
- ☐ Rural
- ☐ Suburban
- ☐ Outside the U.S.

2. Average number of patient encounters/visits per year at your primary place of employment:
- ☐ ≤1,000
- ☐ 1,001–5,000
- ☐ 5,001–10,000
- ☐ 10,001–20,000
- ☐ 20,001–40,000
- ☐ 40,001–60,000
- ☐ 60,001–80,000
- ☐ 80,001–100,000
- ☐ >100,000

3. Will you receive a monetary reward/ compensation from your employer for certification?
☐ Yes ☐ No
If yes:
$ _____________ per hour
$ _____________ per year
$ _____________ one time

4. Number of individuals you supervise:
____

5. Years of experience as an RN (round to nearest whole year):_____________

6. Total years of experience in the field in which certification is desired (round to nearest whole year):
____

7. Primary place of employment (check one):
- ☐ Ambulatory care
- ☐ Physician-managed group practice
- ☐ Home health
- ☐ Hospice
- ☐ Hospital
- ☐ Managed care
- ☐ Nurse-managed group practice
- ☐ Nursing home
- ☐ Long-term care
- ☐ Occupational health/ environmental health
- ☐ Office nursing
- ☐ Public health/community health
- ☐ School health
- ☐ School of nursing/ university/college
- ☐ Federal/military
- ☐ Other:

____

8. Patient population/ conditions representative of your practice (check all that apply):
- ☐ Medical-Surgical
- ☐ Cardiac
- ☐ Endocrine/Diabetes
- ☐ Pulmonary
- ☐ Neurology
- ☐ Renal/Urology
- ☐ Orthopedics
- ☐ Rehabilitation
- ☐ Gerontology
- ☐ Long Term Care
- ☐ Perinatal
- ☐ Post-partum
- ☐ Labor & Delivery
- ☐ Pediatrics
- ☐ ER
- ☐ Trauma
- ☐ Critical Care
- ☐ Other:

____

9. Age range of your primary patient population:
- ☐ 0–1
- ☐ 2–21
- ☐ 22–65
- ☐ 66+

10. Average number of hours worked per week:
- ☐ 8 or fewer
- ☐ 9–16
- ☐ 17–24
- ☐ 25–32
- ☐ 33–40
- ☐ >40

11. Size of facility (total number of beds):
- ☐ N/A
- ☐ 1–100
- ☐ 101–250
- ☐ 251–500
- ☐ >500

12. Is certification part of your employer's job performance/clinical ladder rating criteria?
☐ Yes ☐ No

13. How did you obtain this application?
- ☐ From ANCC website
- ☐ Mailed from ANCC
- ☐ From my school
- ☐ From my workplace
- ☐ At a tradeshow
- ☐ Other:

____

14. Please check the professional organizations in which you are a member (check all that apply):

- ☐ AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
- ☐ AADE American Association of Diabetes Educators
- ☐ AAACN American Academy of Ambulatory Care Nursing
- ☐ ACNP American College of Nurse Practitioners
- ☐ ADA American Diabetes Association
- ☐ ADA American Dietetic Association
- ☐ ANI Alliance for Nursing Informatics
- ☐ APhA American Pharmacists Association
- ☐ APNA American Psychiatric Nurses Association
- ☐ APHA American Public Health Association (Public Health Nursing Section)
- ☐ ANA American Nurses Association
- ☐ ASPMN American Society for Pain Management Nursing
- ☐ ISPN International Society of Psychiatric-Mental Health Nurses
- ☐ GAPNA Gerontological Advanced Practice Nurses Association
- ☐ NACNS National Association of Clinical Nurse Specialists
- ☐ NGNA National Gerontological Nursing Association
- ☐ NNSDO National Nursing Staff Development Organization
- ☐ PCNA Preventive Cardiovascular Nurses Association
- ☐ SVN Society for Vascular Nursing
- ☐ Other: _____________________

Other Demographic Information 9

Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Sex: ☐ M ☐ F

Date of Birth: _____________________
month/date/year

Race/Ethnic Group
- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Black/African-American
- ☐ Hispanic
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Other:

____

To Do List

Date completed:

______________ Read this entire application, front to back.

______________ Determine whether you are/when you will be eligible to take the exam.

______________ Complete any missing requirements such as practice hours or continuing education hours.

______________ Download the full length Test Content Outline and Reference List for this exam at the ANCC website: **www.nursecredentialing.org** These documents are used to create the exam.

______________ Download and read the General Testing and Renewal Handbook from **www.nursecredentialing.org** for a comprehensive listing of policies and critical certification candidate information.

______________ **STUDY PLAN**

Approximately six months before you plan to take your exam, develop a study plan. This could include self study, finding a study buddy or group, taking a review course, taking an on-line narrated course, reviewing current textbooks and articles, or other methods. The key is to have a study plan and follow through with it. For ANCC exam preparation resources, refer to the back cover of this brochure.

______________ Review the sample test questions on the ANCC website at **www.nursecredentialing.org**

______________ **FILL OUT THE APPLICATION**

Two to three months before you plan to take the exam, fill out the application, attaching all required documents.

Required attachments: (please mail everything together in one envelope)

Photocopy of RN license (if your board of nursing issues a paper license)

Official transcript(s) in a sealed envelope. Transcripts may be mailed separately by the university directly to the P.O. Box below.

Photocopy of membership card (if you are claiming a discount)

Payment (if you are paying by check)

Attachments for special circumstances:

Those requesting special accommodations under the Americans with Disabilities Act (ADA) must submit a physician's letter that addresses specific required information. Please go to **www.nursecredentialing.org** or call 1.800.284.2378 for full instructions.

______________ **MAIL APPLICATION**

Mail your application and attachments to:

American Nurses Credentialing Center
P.O. Box 791333
Baltimore, MD 21279-1333

Within two weeks from the date you mailed your application, you will receive a Receipt of Application Notice in the mail. If you do not, call 1.800.284.2378.

Within eight weeks from the date you mailed your application, you will receive either an Eligibility Notice or a letter requesting additional information. Your Eligibility Notice will give you 90 days during which to schedule and take your exam. Read it carefully and follow directions.

______________ **RESULTS**

After you have taken your exam, you will receive results in the mail within two weeks. If you passed, you will receive a certificate and pin within two months. Certifications are good for 5 years.

______________ Request your one free verification of certification at **www.nursecredentialing.org** Additional verifications of certification can also be ordered from this site. ANCC does not automatically send verification to your state board of nursing or employer. Please request the verifications you need.

______________ After you pass the exam, download the Certification Renewal materials from the ANCC website at **www.nursecredentialing.org** and begin planning for your certification renewal.

Exam Preparation Resources

Review Seminars

Review Seminars for certification exams are available for fifteen different nursing specialties at various hospitals and schools of nursing across the country. Participants receive contact hours. Seminar schedule and registration at: **www.nursecredentialing.org**

Study Groups

Using the content from the seminars, the faculty lecture on the material during several telephone conference calls scheduled during a specific time period. Look for the "Study Group" courses in the seminar schedule. Participants receive contact hours. Study Group schedule and registration at: **www.nursecredentialing.org**

On-Line Narrated Review Courses

Our On-Line Narrated Review Courses contain the same content as our popular Review Seminars, with the voice over of an instructor talking the student through the material. After you register for the course, you will have three months in which to complete the materials. Participants receive contact hours. For more information and to register: **www.nursecredentialing.org**

Review and Resource Manuals

Written by nursing experts in each specialty, these manuals help candidates prepare for a variety of certification exams by enhancing your critical thinking skills and identifying strengths and weaknesses. Contact hours available on-line for an additional fee.
Order manuals at: **www.nursecredentialing.org**

Certified Nurse Products

Once you have passed your exam, celebrate your accomplishment with pins, plaques, and other recognition items. **www.nursecredentialing.org**

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), provides individuals and organizations throughout the nursing profession with the resources they need to achieve practice excellence. ANCC's internationally renowned credentialing programs certify nurses in specialty practice areas; recognize healthcare organizations for promoting safe, healthy work environments through the Magnet Recognition Program® and the Pathway to Excellence Program™; and accredit providers of continuing nursing education. In addition, ANCC provides leading-edge information and education services and products to support its core credentialing programs. All programs of the ANCC are administered without discrimination on the basis of age, color, creed, disability, gender, health status, lifestyle, nationality, race, religion, or sexual orientation. ANA is accredited as a provider of continuing nursing education by ANCC's Commission on Accreditation. ANA is approved as a provider by the California Board of Registered Nursing, Provider number 6178.

P.O. Box 791333
Baltimore, MD 21279-1333
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www.nursecredentialing.org

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