AMERICAN ACADEMY OF NURSE PRACTITIONERS CERTIFICATION PROGRAM

NATIONAL RECERTIFICATION APPLICATION

Please complete the following application and return to the American Academy of Nurse Practitioners Certification Program with your documentation of practice and continuing education or official program transcript, documentation of current RN licensure and fees.

RETURN TO: AMERICAN ACADEMY OF NURSE PRACTITIONERS CERTIFICATION PROGRAM
CAPITOL STATION, LBJ BUILDING • P. O. BOX 12926 • AUSTIN, TX 78711

FEES

Clinical & Continuing Education	❑ Members $120	❑ Nonmembers $195
Computer-Based Testing	❑ Members $240	❑ Nonmembers $315

AANP Membership Number: /___/___/___/___/___/___/___/___/ Date of Initial Certification____________________

❑ Enclosed is my check payable to: American Academy of Nurse Practitioners Certification Program

❑ Charge my credit card: ❑ Visa ❑ Mastercard ❑ Amex #____

Expiration Date:______________ Signature____

Name on Card (Please print)____

PRINT OR TYPE:

Name:

____

Last First Middle Social Security Number

Address:

____

Street

____

City State Zip Code

Phone: Home (_______)_________________________ Work (_______)__________________________

E-mail____ Fax (_______)__________________________

State(s) of current R.N. Licensure **License Number** **Date of Expiration**

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❑ Copy of current RN License is enclosed

❑ **I am applying for Recertification Through Practice and Continuing Education:**

❑ ADULT NURSE PRACTITIONER ❑ FAMILY NURSE PRACTITIONER

❑ **I am applying for Recertification Through Computer-Based Examination:**

❑ ADULT NURSE PRACTITIONER ❑ FAMILY NURSE PRACTITIONER

NURSE PRACTITIONER PROGRAM INFORMATION:

Name of Program________________________________University____

Program Address____

Nurse Practitioner Program Speciality:___________________________Check: MSN ( ) or Post Masters ( )

Date of Program Completion: Month_______Year_______Degree Conferred:_____________________________________

IF RECERTIFYING BY EXAMINATION, COMPLETE THE FOLLOWING:

PREFERRED WINDOW OF EXAMINATION______________________________(AN EXAMINATION APPLICATION WILL BE SENT.)

IF RECERTIFYING THROUGH NURSE PRACTITIONER CLINICAL PRACTICE AND CONTINUING EDUCATION, COMPLETE THE FOLLOWING:

Nurse Practitioner Clinical Practice:

NUMBER OF NP CLINICAL PRACTICE HOURS SINCE DATE OF PREVIOUS CERTIFICATION______________________________

	NP Clinical Practice Sites Names & Complete Addresses	Position Title/ Description of Primary Care Responsibilities *(Include only Nurse Practitioners Clinical Activity.)*	Dates & Hours of NP Practice Since Previous Certification
(1)			
(2)			

A separate sheet may be attached if additional space is needed.

Continuing Education: Complete Attached Continuing Education Document RC 101. In order to facilitate review, please list copies in chronological order.

I certify that all the information contained in this application for recertification is true and correct.

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Applicant Date

CHECK LIST FOR COMPLETION AND ENCLOSURES:

- ❑ Verification of Current RN Licensure enclosed
- ❑ Payment Enclosed *(check signed or credit card number complete)*
- ❑ All Items on application are completed
- ❑ All continuing education documentation is included
- ❑ Application is signed

For questions & inquiries, contact the Certification Program at (512) 442-5202 cert@aanp.org

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