

# AMERICAN ACADEMY OF NURSE PRACTITIONERS CERTIFICATION PROGRAM

## ADULT NATIONAL CERTIFICATION EXAMINATION APPLICATION

Please complete the following application and return to the American Academy of Nurse Practitioners Certification Program with your 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

### EXAMINATION FEES:

#### Computer-based:

- Members—CBT \$240
- Nonmembers—CBT \$315
- Additional Late Fee \$50

#### AMERICAN ACADEMY MEMBERSHIP NUMBER:

\_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_/

#### SOCIAL SECURITY NUMBER:

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

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

Charge my credit card:       Visa     Mastercard     Amex     Discover

Credit Card No \_\_\_\_\_

Expiration Date: \_\_\_\_\_                      Signature \_\_\_\_\_

Name on Card (Please print) \_\_\_\_\_

### PRINT OR TYPE:

Name: \_\_\_\_\_  
Last    First    Middle

(Must appear same as on legal documentation used for testing admittance.)

Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City    State    Zip Code

Phone: Home (\_\_\_\_\_) \_\_\_\_\_                      Work (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_                      Fax (\_\_\_\_\_) \_\_\_\_\_

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

Copy of current RN License is enclosed

I am applying for Computer-Based Testing:

Adult Nurse Practitioner

Preferred Window for Examination \_\_\_\_\_

Continued on the back

**NURSE PRACTITIONER PROGRAM INFORMATION:**

Name of Program: \_\_\_\_\_

University: \_\_\_\_\_

Program Address: \_\_\_\_\_

Nurse Practitioner Program Specialty : \_\_\_\_\_ Check: MSN ( ) or Post Masters ( )

Name of Program Director: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Program Completion: Month \_\_\_\_ Year \_\_\_\_ Date Degree Conferred: \_\_\_\_\_

**PROGRAM DESCRIPTION:**

<b>Didactic:</b>	<b>Number of Credit Hours</b>	<b>Course Number</b>	<b>Year Taken</b>
Pathophysiology	_____	_____	_____
Pharmacology	_____	_____	_____
Advance Physical Assessment	_____	_____	_____
Courses in Specialty	_____	_____	_____
	_____	_____	_____

**Clinical:**

**Total Number of Clinical Clock Hours:** \_\_\_\_\_

	<b>Name &amp; Address of Practice Site</b>	<b>Site Specialty</b>	<b>Preceptor's Name and Credentials</b>
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____
(4)	_____	_____	_____

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

**An Official Transcript has been sent**

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

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

**CHECK LIST FOR COMPLETION AND ENCLOSURES:**

- Official Transcript (If you have not completed your program prior to the application deadline, send an official transcript of work to date. Documentation of program completion will be required in order to sit for the exam.)
- Verification of Current RN Licensure enclosed
- Payment Enclosed (*check signed or credit card number complete*)
- All Items on application are completed
- All documentation is included
- Application is signed

**For questions & inquiries,  
contact the Certification Program  
at (512) 442-5202  
[www.aanpcertification.org](http://www.aanpcertification.org)**