Application for CRRN Renewal by Points of Credit

June 30, 2020 Expiration Date

Please print all information.

Name: _____
Last First Middle Initial

Former name: _____

Address: _____
Number & street Apt. #

_____
City State Zip

Phone: ( ) _____ ( ) _____
Home Work

Certification #: _____
Please copy number from your CRRN certificate

E-mail address: _____

Instructions

1. Go to www.rehabnurse.org and review the CRRN renewal requirements. By completing and submitting this application, you are affirming that you meet the published criteria.
2. Sign and date the *attestation of eligibility*.
3. Include your RN# and state.
4. Provide contact information for two professional colleagues who are able to provide verification of your rehabilitation nursing experience.
5. **Include the renewal fee and mail the complete application (3 pages) to**
   RNCB
   8735 W. Higgins Road, Suite 300
   Chicago, IL 60631

Attestation of eligibility

By signing and submitting this application, I attest that I have read the CRRN certification renewal requirements and affirm that:

- I have a current, unrestricted RN license.
- I have completed 60 points of credit between July 1, 2015, and June 30, 2020, which meet the published criteria.
- I have at least 1000 hours of rehabilitation nursing experience within the 5-year certification period.

I hereby apply for renewal of the Certified Rehabilitation Registered Nurse credential, verify that all information provided is accurate and affirm that I meet all published criteria at the time of application. I authorize the evaluation and validation of my credentials by RNCB. In furtherance of my application, I authorize any individual or organization who may have information concerning my credentials to provide such information to RNCB. I hereby waive any claim for damages, or otherwise, that I may have against RNCB and any individual or organization that supplies such information by reason of any act or omission by any of them taken in good faith in connection with this application. I understand that the decision as to whether I qualify for certification rests solely and exclusively in RNCB and that its decision is final. By signing and submitting this application I also agree to be bound by all policies and procedures of RNCB.

Legal signature of candidate: _____

Date: _____

Current registered nurse #: _____

State: _____ **Expiration date:** _____

Verification of work experience

You must include contact information for two professional colleagues who are able to verify that you have at least 1000 hours of rehabilitation nursing experience within the 5-year certification period. One colleague must be either your immediate supervisor OR another CRRN. The second colleague may be any other professional colleague such as another nurse, physician, therapist, social worker, etc. Please provide complete contact information. In the event your application is selected for audit, this individual will be contacted to verify your rehabilitation nursing experience.

An alternative verification is available for nurses who do not have an immediate supervisor or CRRN colleagues. Please visit www.rehabnurse.org for details.

Reference #1 (CRRN or immediate supervisor)

PLEASE NOTE: IF ONE OF THE BOXES BELOW IS NOT CHECKED, YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE AND YOU WILL BE UNABLE TO RENEW YOUR CERTIFICATION UNTIL THE INFORMATION IS PROVIDED.

This individual is (check one): ❑ CRRN ❑ Candidate's Immediate Supervisor

Last name	First name		MI
Employer	Title		
Street address (work)	City	State	ZIP
Telephone (work)	Email (work)		
Street address (home)	City	State	ZIP
Telephone (home)	Email (home)		

Reference #2 (professional colleague)

PLEASE NOTE: IF ONE OF THE BOXES BELOW IS NOT CHECKED, YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE AND YOU WILL BE UNABLE TO RENEW YOUR CERTIFICATION UNTIL THE INFORMATION IS PROVIDED.

This individual is (check one): ❑ CRRN ❑ Candidate's immediate supervisor ❑ Professional colleague

Last name	First name		MI
Employer	Title		
Street address (work)	City	State	ZIP
Telephone (work)	Email (work)		
Street address (home)	City	State	ZIP
Telephone (home)	Email (home)		

Payment information

Fees (check the appropriate box.)

On or before 12/31/2020

❒ $280 ARN member

❒ $415 Non-member

❒ $130 Join ARN/renew ARN membership

Additional for chapter membership see www.rehabnurse.org for details.

Chapter name: _____ Chapter dues: _____

Total amount enclosed: _____

Payment (Please check appropriate box.)

❒ Check or money order enclosed **payable to Rehabilitation Nursing Certification Board**

❒ American Express ❒ MasterCard ❒ VISA

Account # | | | | | | | | | | | | | | | | | | | | | Expiration Date | | | | | | |

Signature: _____

Staple check here, if applicable.