2008-2009 Testing Information / Certification Application Form

Clinical Nurse Specialist in Child/ Adolescent Psychiatric & Mental Health

ANCC proudly offers certification for

Clinical Nurse Specialist in Child/ Adolescent Psychiatric & Mental Health

The Clinical Nurse Specialist in Child/Adolescent Psychiatric & Mental Health Nursing (CNS) is a registered nurse prepared in a graduate level child/adolescent psychiatric & mental health clinical nurse specialist program to treat children and adolescents with mental health/psychiatric disorders using a variety of therapeutic and interpersonal techniques. Knowledge of child development and conceptualization of the child as part of a family system is essential to providing expert care. The Child/Adolescent Psychiatric & Mental Health CNS utilizes diagnostic and assessment skills to provide therapeutic services through multiple modalities. The CNS practices in a variety of settings and is actively engaged in education (e.g. patient, staff, students, and colleagues), case management, expert clinical practice, consultation, research, and administration.

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 child/adolescent psychiatric and mental health program accredited by the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC). A minimum of 500 faculty supervised clinical hours in the Child/Adolescent Psychiatric & Mental Health CNS role & specialty must be included in the educational program. The Child/Adolescent Psychiatric & Mental Health CNS graduate program must include course work in:
  - advanced health assessment
  - advanced pharmacology
  - advanced pathophysiology
  - clinical training in at least two psychotherapeutic treatment modalities

All requirements must be completed prior to application for the examination.

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

Testing Information

Clinical Nurse Specialist in Child/Adolescent Psychiatric & Mental Health

Overview of test content outline

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

I. Mental Health Practice

A. Application of social and behavioral science theories, concepts, models, & frameworks
B. Application of growth and development theories, concepts, models, and frameworks

II. Advance Nursing Practice

A. Nursing process
B. Scope and standards of practice
C. Communication principles and skills
D. Documentation standards and utilization of informatics
E. Legal issues
F. Ethical principles

III. Organization/Network/ Health System

A. Organization, network, health system, and change theories
B. Continuous quality improvement, outcome measures, risk management
C. Laws and regulations regarding healthcare delivery models and educational services
D. Case management

IV. Basic and Applied Science

A. Pathophysiology and psychopathology
B. Genetics
C. Anatomy and physiology
D. Child/adolescent pharmacology and psychopharmacology
E. Nutritional science

V. Research Priorities in Nursing

A. Research methodology
B. Evidence-based nursing practice

VI. Educational Program Development, Implementation, and Evaluation

A. Learning needs assessment
B. Learning theories
C. Teaching methods
D. Evaluation

VII. Professional Skills and Role Development

A. Leadership
B. Principles and activities of mentoring and preceptorship
C. Consultation
D. Collaboration and networking skills
E. Self awareness
F. Professional information dissemination

VIII. Community/Public Health

A. Primary prevention
B. Emergency/disaster response
C. Epidemiology

Application Fees

	2008-2009	
ANA Member	$270	Required attachment: A copy of your American Nurses Association membership card
APNA Member	$290	Required attachment: A copy of your American Psychiatric Nurses Association membership card
Discount	$340	Required attachment: A copy of your National Association of Clinical Nurse Specialists or International Society of Psychiatric-Mental Health Nurses membership card
Non-Member	$390	
International Testing	$125	See **www.nursecredentialing.org/cert/foreignsite.html** 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.

Complete information about the application and testing process is in the General Testing and Renewal Handbook available at **www.nursecredentialing.org/cert/application.html** From this website, you can type into and print your application. Please sign, attach required documents, and mail the complete application for processing.

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. Submit an application, copy of RN 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

DETACH HERE
Complete application and mail to ANCC.

ANCC Certification Application Form

Staff use only: ☐ E ☐ R ☐ P ☐ CC ☐ NE

Clinical Nurse Specialist in Child/Adolescent Psychiatric & Mental Health

CNSCHPSY08v2 03/08

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 _____

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 _____

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)

Amount Enclosed: _____

Amount to be charged: _____

Promotional Code (if applicable): _____

Account Number _____ Exp. Date _____

Print Name on Card _____ Signature _____

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.cert.ADA.html**

Validation of Clinical Nurse Specialist Education Program

INSTRUCTIONS

Candidate: Allow sufficient time for the program director to complete and return this form to you for inclusion with your application. Applications received without this form or with an incomplete form incur a delay that can impact your ability take the exam.

The current program director completes items 1-10 and returns the form to the candidate to include with an 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/schoolcodes.cfm**)

____
Program Name

____
Program Address

____
Program Telephone Number

2. Type of degree conferred:

☐ Master's clinical nurse specialist program

☐ Post-Master's clinical nurse specialist program (**Required Attachment:** Provide a detailed description of content and clinical hours accepted from all previous graduate programs.)

☐ Doctorate

3. Date program completed: ______________________

4. Date degree conferred: ______________________

5. Check area of concentration completed:

☐ Adult Health Clinical Nurse Specialist

☐ Adult Psychiatric & Mental Health Clinical Nurse Specialist

☐ Advanced Diabetes Management Clinical Nurse Specialist

☐ Child/Adolescent Psychiatric & Mental Health Clinical Nurse Specialist

☐ Gerontological Clinical Nurse Specialist

☐ Pediatric Clinical Nurse Specialist

☐ Public/Community Health Clinical Nurse Specialist

6. Please indicate the title and course number of the following content:

Advanced Health Assessment ______________________

____

Pharmacology ______________________

____

Pathophysiology ______________________

____

7. For Psychiatric-Mental Health Specialty Only

Please check the psychotherapeutic treatment modalities in which the candidate received supervised clinical training at the graduate or post graduate level:

☐ Individual ☐ Group

☐ Family ☐ Expressive Therapies

☐ Milieu ☐ Play Therapy

☐ Other

8. Total number of Didactic: ______________________ **(in credit hours)**

9. Total number of Clinical: ______________________ **(in clock hours)**

10. Program Director Signature Your signature on this form attests that the above named individual has completed the program indicated on this document.

____
Program Director (Print Name)

____
Program Director's Signature ______________________ Date

Form may be duplicated as needed.

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 (do not include high school).
Required attachment: All official advanced degree transcripts.
Please attach additional page if necessary.

School Name ______________________ School Code ______________________

Major/Area of Study ______________________ Date Degree Conferred ______________________

School Name ______________________ School Code ______________________

Major/Area of Study ______________________ Date Degree Conferred ______________________

School codes: Available via Fax-on-Demand 1.888.880.2404 Doc #116 or on-line at **www.nursecredentialing.org/cert/schoolcodes.cfm**

Licensure Information 6

Required attachment: Attach a copy of license

Current RN License Number ______________________

State ______________________ Expiration Date (month/date/year) ______________________

Statement of Understanding 7

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

I authorize the Commission on Certification to make whatever inquiries and investigations that it deems necessary to verify my credentials and professional standing. I expressly acknowledge 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.

To the best of my knowledge, the information on this application is true, complete, and correct. I attest by my signature that I meet all eligibility requirements for certification, in effect for the year in which this application is made as stipulated in the most current requirements on the ANCC website: **www.nursecredentialing.org** I attest by my signature that I will maintain an active registered nurse licensure throughout the entire period during which I am certified. I understand that any misstatement of any material fact submitted upon application for certification may be sufficient cause for ANCC to bar me from the examination, to invalidate the results of my examination, to withhold certification, to revoke certification, or to take other appropriate action.

I hereby attest that I meet the eligibility criteria as stated on the front of this brochure and ANCC website for this certification exam.

(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

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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 a registered nurse/licensed practitioner (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
- ☐ NACNS National Association of Clinical Nurse Specialists
- ☐ NCGNP National Conference of Gerontological Nurse Practitioners
- ☐ NGNA National Gerontological Nursing Association
- ☐ NNSDO National Nursing Staff Development Organization
- ☐ PCNA Preventive Cardiovascular Nurses Association
- ☐ SPN Society of Pediatric Nurses
- ☐ SVN Society for Vascular Nursing
- ☐ Other: ______________________

Other Demographic Information

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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.

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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.

_______________ Take the practice exam 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. Transcripts may be mailed separately by the university directly to the P.O. Box below.)

- Photocopy of nursing license
- Official transcript(s) in a sealed envelope. Transcripts may be mailed separately by the university directly to the P.O. Box.
- 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/cert/ADA.html** 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 six 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/cert/verify1.html** using the paper form. Please note, you can not request a free verification using the on-line system.

_______________ After you pass the exam, download the Certification Renewal materials from the ANCC website at **www.nursecredentialing.org** and begin tracking your renewal requirements.

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/cert/revseminars.html**

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/cert/revseminars.html**

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/cert/webcourses.html**

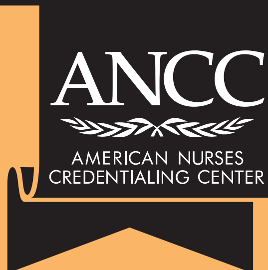
Review and Resource Manuals

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/cert/revmanuals.html**

Certified Nurse E-Store

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

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.



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