



ANCC proudly offers certification for

Family Nurse Practitioner

The Family Nurse Practitioner (FNP) is a registered nurse prepared in a graduate level family nurse practitioner program to provide a full range of health care services on the wellness-illness health care continuum at an advanced level to individuals of all ages and families. The FNP practice includes independent and interdependent decision making, and is directly accountable for clinical judgments. The graduate level preparation expands the FNP's role to include differential diagnosis and disease management, participation in and use of research, development and implementation of health policy, leadership, education, case management, and consultation.

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 family nurse practitioner 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 must be included in your family nurse practitioner program. The FNP graduate program must also include content in:
 - > advanced health assessment
 - > advanced pharmacology
 - > advanced pathophysiology
- > AND, content in
 - > health promotion and disease prevention, and
 - > differential diagnosis and disease management

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

For more information: www.nursecredentialing.org

Testing Information

Family Nurse Practitioner

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

I. Clinical Management as associated with Notes 1 and/or 2

- A. Standards of advance practice
- B. Clinical guidelines
- C. Pharmacotherapeutics
- D. Clinical therapeutics
- E. Clinical decision-making
- F. Documentation
- G. Safety
- H. Theory application

II. Professional Role and Policy

- A. Health care/public policy
- B. Ethics
- C. Scope of practice
- D. Access to care
- E. Coordination of care

III. Nurse Practitioner and Patient Relationship as associated with Notes 1 and/or 2

- A. Cultural competence
- B. Therapeutic communication
- C. Teaching/coaching
- D. Patient advocacy

IV. Assessment of Acute and Chronic Illness as associated with Notes 1 and/or 2

- A. Epidemiology/disease control
- B. Anatomy/anatomical variants
- C. Physiology
- D. Pathophysiology
- E. Psychosocial
- F. Diagnostic reasoning

V. Research

- A. Research process/utilization
- B. Continuous process improvement/outcomes evaluation

VI. Health Promotion and Disease Prevention as associated with Notes 1 or 2

- A. Epidemiology/risk analysis
- B. Genetics
- C. Risk reduction and health behavior guidelines
- D. Growth and development across the lifespan
- E. Screening
- F. Wellness assessment

Note 1: Life Span Areas

- A. Aging adult (65 and older)
- B. Adult (18 - 64)
- C. Adolescent (11 - 21)
- D. Child (12 months - 10)
- E. Infant (birth - 12 months)
- F. Child-bearing woman

Note 2: Problem Areas

- A. Head, eyes, ears, nose, and throat
- B. Cardiovascular/respiratory
- C. Renal, GI, GU
- D. Reproductive-male & female
- E. Musculoskeletal/neurologic
- F. Hematopoietic/immune/lymphatic
- G. Immune/allergies/endocrine
- H. Integumentary
- I. Psychosocial
- J. Communicable/infectious disease
- K. Emergencies
- L. Functional limitations
- M. Normal and abnormal development
- N. Learning disabilities
- O. Nutrition
- P. Oncology
- Q. Victims of violence
- R. Dependency

Application Fees

2008-2009

ANA Member	\$270	Required attachment: A copy of your American Nurses Association membership card
Discount	\$340	Required attachment: A copy of your American College of Nurse Practitioners 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
Family Nurse Practitioner

Staff use only: E R P CC NE

NPFAM08v2 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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Nurse Manager | <input type="checkbox"/> Associate/Assistant Administrator | <input type="checkbox"/> Clinical/Staff Nurse |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Educator | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Administrator/DON/CNO/VP Nursing | <input type="checkbox"/> Researcher | <input type="checkbox"/> Consultant |
| | | <input type="checkbox"/> Other: _____ |

Payment

2

Personal Check/Money Order (payable to ANCC) Amount Enclosed: _____

Charge Card (MasterCard or VISA only) 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 Nurse Practitioner 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 nurse practitioner program
- Post-Master's nurse practitioner program
(Required Attachment: Provide a detailed description of the course work and clinical hours accepted from previous graduate programs.)
- Doctorate

3. Date program completed: _____

4. Date degree conferred: _____

5. Check area of concentration completed:

- Acute Care Nurse Practitioner
- Adult Nurse Practitioner
- Adult Psychiatric-Mental Health Nurse Practitioner
- Advanced Diabetes Management Nurse Practitioner
- Family Nurse Practitioner
- Family Psychiatric-Mental Health Nurse Practitioner
- Gerontological Nurse Practitioner
- Pediatric Nurse Practitioner

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

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

Advanced Health Assessment _____

Pharmacology _____

Pathophysiology _____

Diagnosis and medication management of psychiatric illness (**Psychiatric and Mental Health Nurse Practitioners only**) _____

7. For Psychiatric-Mental Health Nurse Practitioner 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)

Education

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

Required attachment: Attach a copy of license

Current RN License Number

State Expiration Date (month/date/year)

Statement of Understanding

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

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):
- | | |
|---|--|
| <input type="checkbox"/> AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation | <input type="checkbox"/> ASPMN American Society for Pain Management Nursing |
| <input type="checkbox"/> AADE American Association of Diabetes Educators | <input type="checkbox"/> ISPN International Society of Psychiatric-Mental Health Nurses |
| <input type="checkbox"/> AAACN American Academy of Ambulatory Care Nursing | <input type="checkbox"/> NACNS National Association of Clinical Nurse Specialists |
| <input type="checkbox"/> ACNP American College of Nurse Practitioners | <input type="checkbox"/> NCGNP National Conference of Gerontological Nurse Practitioners |
| <input type="checkbox"/> ADA American Diabetes Association | <input type="checkbox"/> NGNA National Gerontological Nursing Association |
| <input type="checkbox"/> ADA American Dietetic Association | <input type="checkbox"/> NNSDO National Nursing Staff Development Organization |
| <input type="checkbox"/> ANI Alliance for Nursing Informatics | <input type="checkbox"/> PCNA Preventive Cardiovascular Nurses Association |
| <input type="checkbox"/> APhA American Pharmacists Association | <input type="checkbox"/> SPN Society of Pediatric Nurses |
| <input type="checkbox"/> APNA American Psychiatric Nurses Association | <input type="checkbox"/> SVN Society for Vascular Nursing |
| <input type="checkbox"/> APHA American Public Health Association (Public Health Nursing Section) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> ANA American Nurses Association | |

Other Demographic Information

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

- | | |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black/African-American | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hispanic | |

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.

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)

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 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/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 instantly at the test site. 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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