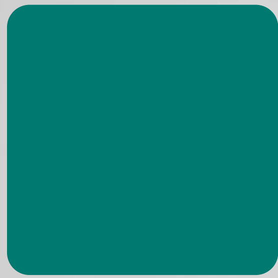
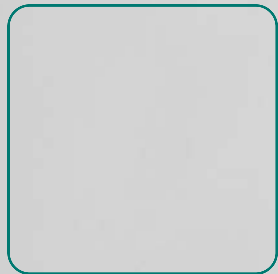
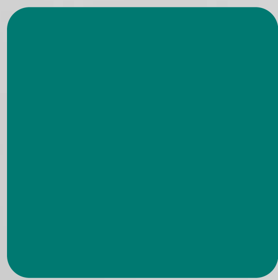
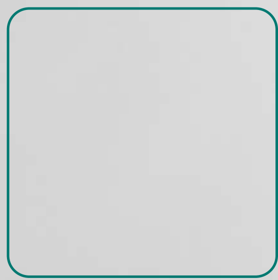
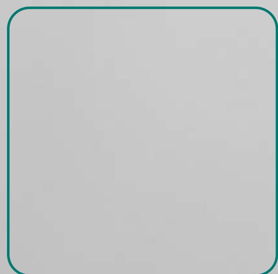
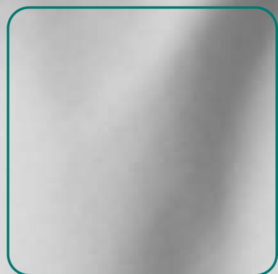
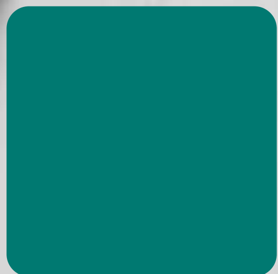
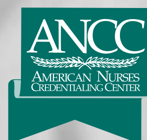



Pain Management Certification Examination



Description of Practice

The nurse in pain management provides comprehensive nursing care to clients experiencing acute and chronic pain from a variety of causes such as cancer, labor and deliver, post operative, headaches, etc. The nurse uses pain management knowledge and skills to make clinical decisions, develop client diagnosis, and establish a plan of care, and evaluate the effectiveness of care for patients of all ages and special populations. Care is provided in collaboration with other health care professionals. Nurses engaged in pain management adhere to the scope of practice authorized by state and federal regulations in which the practice occurs. The certification will be available October 2005.

Pain Management Eligibility Criteria

1. Hold a current, active, unrestricted professional RN license in the United States or its territories.
2. Have practiced the equivalent of 2 years full time as a registered nurse in the United States or its territories.
3. Have practiced in a nursing role which involves aspects of pain management (e.g. pain assessment and management, pain management education, research, etc.) at least 2,000 hours in the past three years prior to applying to take the examination
4. Have 30 hours of continuing education in the three years prior to taking the exam, of which a minimum of 15 hours must be related to pain management.

Overview of Test Content Outline

(visit www.nursecredentialing.org, for an in-depth test content outline and references and sample questions)

I. Pathophysiology of Pain

A. Definition of Pain (Subjective Nature, Biopsychosocial, Suffering)
B. Nociceptive vs. Neuropathic Pain
C. Transient (Acute) vs. Persistent (Chronic) Pain
D. Science of Pain
E. Common Pain Syndromes
F. Negative Physiological and Psychological Consequences of Unrelieved Pain
G. Addiction, Tolerance, Physical Dependence and Pseudoaddiction

II. Pain Assessment (As associated with note #1)

A. Components/Elements
B. Tools
C. Associated Symptoms
D. History Taking and Physical Exam
E. Functional Assessment/Quality of Life
F. Assessment of Patient/Family's Barriers to Pain Management
G. Coping Strategies
H. Reassessment of Interventions

III. Interventions (Associated with Note #1)

A. Pharmacological Treatment
B. Non-Pharmacological Treatments
C. Complementary/Alternative Therapies
D. Principles of Analgesic Management

IV. Side Effects (Associated with Note #3)

A. Prevention
B. Assessment
C. Management
D. Difference between Allergic Reaction, Side Effect, Adverse Effect
E. Tolerance

V. Patient/Family Education & Counseling

(Associated Notes #2)

A. Barriers to Patient/Family Education
B. Clinical Application of Teaching and Learning
C. Crisis Management
D. Evaluation of Understanding/Comprehension/Competency

VI. Collaborative/Institutional Issues

A. Tools of Communication
B. Goal-Setting
C. Standards and Scope of Practice of the Pain Management Nurse
D. Advocacy
E. Ethics
F. Research

Note #1: Life Span Populations

1. Preverbal Children
2. School Age
3. Adolescent
4. Adult
5. Older Adults
6. Non-age Specific

Note #2: Specialty Populations

1. Cognitively Impaired
2. Chemically Sedated
3. Addiction
4. Minorities & Cultural Consideration
5. Pregnancy

Note #3: Common Side Effects

1. Opioid (pruritis, contact dermatitis, sedation, nausea, vomiting, constipation, respiratory depression)
2. Non-Opioid (GI upset, GI bleed, renal, liver, delirium)
3. Adjunctives (Central Nervous System effects, renal, liver)

Fees

Member (ANA)	**$180**
Discount (ASPMN)	**$250**
Non Member	**$320**

Please complete the attached application and continuing education form and send with the appropriate fee to:

American Nurses Credentialing Center
P.O. Box 791333
Baltimore, MD 21279-1333

After you file

1. After your application fee is processed, a Notice of Application Received is sent to confirm receipt of your application.
   - If the information on the form is correct, maintain a copy of the form with your copy of your application packet.
   - If the information on the form is incorrect, send your changes in writing to the address on the form.
2. Once you are eligible to take an exam:
   - You will receive an eligibility-to-test notice from ANCC.
   - Approximately, two weeks before the test date, an admission ticket with the location and address of the test site will be mailed to you directly from the designated testing vendor (Thomson Prometric).
3. If you are deemed ineligible to take an examination, you will receive a letter stating the reason why you are ineligible to take an exam.

P.O. Box 791333 Baltimore, MD 21279-1333 • 301-628-5000 • 800-284-2378

OFFICE USE ONLY
☐ VISA ☐ MC
☐ CHECK ☐ M.O.
☐ AMT. PAID ________

ST:
☐ E ☐ R
☐ P ☐ QC
☐ NE

NOTE: The information on this application must be complete and accurate. You must read and sign the statement of understanding that appears at the end of this application. If questions are unanswered or applicable boxes not filled in, your application will be considered incomplete and will not be processed. If you do not sign the statement of understanding, your application will be considered incomplete and will not be processed.

I. PERSONAL DATA - General Information Use your legal name on the application. This name must match the name on your photo identification that will be used for entry to take the examination. This will be name printed on your certificate.

Last Name | First Name | MI

Home Address | Social Security Number

City | State | Zip Code

Home Phone | Fax | E-Mail

Business Name

Business Address

City | State | Zip Code

Office Phone | Fax | E-Mail

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/Pacific Islander

1. I have a disability as defined by the American with Disabilities Act (ADA) and require a special accommodation. Call 1800-284-2378 for additional information.

2. Exam title and code: **Pain Management - 56**

3. Check the month you will take the exam: ☐ May ☐ October
See www.nursecredentialing.org for exam dates, deadline, and locations.

4. Location:____________________ Site Code:__________
See www.nursecredentialing.org for exam dates, deadlines, and locations.

B. Licensure Information (Attach a copy of license)

1. Current RN License Number: ______________________

State: ____________ Expiration Date: ________________
(month/date/year)

C. Education

Please fill in all boxes that apply.

01 ☐ Diploma
02 ☐ Associate Degree/Other Field
03 ☐ Associate Degree in Nursing
04 ☐ Baccalaureate in Nursing
05 ☐ Baccalaureate in Other Field
06 ☐ Master's in Nursing
07 ☐ Master's in Other Field
08 ☐ PhD Other Field
09 ☐ EdD
10 ☐ DNSc
11 ☐ PhD in Nursing
12 ☐ ND

Graduate Institution:
____

Major:
____

Date degree completed:
____

Post-Graduate Institution:
____

Major:
____

Date degree completed:
____

II. DEMOGRAPHIC DATA - General Information

1. Do you currently hold an ANCC Certification?
☐ Yes ☐ No If "yes'" please indicate certification
____

2. Are you certified by other organizations?
☐ Yes ☐ No If yes, please indicate certification credential and organization name/s:
____
____
____

Practice Please fill in all boxes that apply.

1. Primary field/place of employment:

1 ☐ Hospital
2 ☐ Nursing Home/Long-Term Care
3 ☐ Home Health
4 ☐ Nurse-Managed Practice
5 ☐ Independent/Solo Practice/Self-Employed
6 ☐ Public Health/Community Health
7 ☐ School Health
8 ☐ Office Nursing (Mental Health Center)
9 ☐ Occupational /Environmental Health
☐ Federal/Military/VA
10 ☐ Ambulatory Care
11 ☐ HMO/Managed Care
12 ☐ Group Home
13 ☐ School of Nursing/University
14 ☐ Hospice
15 ☐ Per diem/agency/travel nurse
16 ☐ Other: ________________ (Specify)

2. Type of Primary Position

1 ☐ Nurse Manager/Charge Nurse
2 ☐ Staff
3 ☐ Nurse Practitioner
4 ☐ Clinical Nurse Specialist
5 ☐ Administrator/DON/VP Nursing
6 ☐ Associate or Assistant Administrator
7 ☐ Educator
8 ☐ Consultant
9 ☐ Researcher
10 ☐ Case Manager
11 ☐ Other: ________________ (Specify)

3. Years of experience as a registered nurse:

1 ☐ 0-2
2 ☐ 3-5
3 ☐ 6-10
4 ☐ 11-15
5 ☐ 16-20
6 ☐ 21-25
7 ☐ 26-30
8 ☐ 31 or greater

4. Total years of experience in the field in which recertification is desired:

1 ☐ 0-2
2 ☐ 3-5
3 ☐ 6-10
4 ☐ 11-15
5 ☐ 16-20
6 ☐ 21-25
7 ☐ 26-30
8 ☐ 31 or greater

5. Size of facility:

1 ☐ N/A
2 ☐ 1-100
3 ☐ 101-250
4 ☐ 251-500
5 ☐ More than 500

6. Location of facility:

1 ☐ Urban
2 ☐ Rural
3 ☐ Suburban
4 ☐ Outside the U.S.

7. Patient encounters/Patient visits per/year at your primary place of employment:

1 ☐ Less than 1,000
2 ☐ 1,000-5,000
3 ☐ 5,001-10,000
4 ☐ 10,001, 20,000
5 ☐ 20,001-40,000
6 ☐ 40,001-60,000
7 ☐ 60,001-80,000
8 ☐ 80,001-100,000
9 ☐ 100,001 or greater

8. Number of individuals you supervise:

1 ☐ 1-4
2 ☐ 5-10
3 ☐ 11-50
4 ☐ 51-150
5 ☐ More than 150
6 ☐ Not Applicable

9. Patient population – types of patient conditions representative of your practice:

____

10. Patient/client age range:

1 ☐ 0-1
2 ☐ 2-21
3 ☐ 22-65
4 ☐ 66+

11. Number of hours worked per week:

1 ☐ less than 8
2 ☐ 8-16
3 ☐ 17-24
4 ☐ 25-32
5 ☐ 33-40
6 ☐ 41 or greater

12. Do/will you receive any monetary reward for certification? ☐ Yes ☐ No

13. If you answered "yes'" please indicate the amount:

per hour ________________
per year ________________
one time ________________

14. Is certification part of the job performance/ clinical ladder rating criteria? ☐ Yes ☐ No

15. List the professional organization/s of which are a member:

____
____
____

ALL APPLICANTS MUST COMPLETE THIS SECTION - 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 the ANCC may enter into agreements to release anonymous and aggregate data to external researchers. Otherwise, subject to the above 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 catalog. 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.

(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.)

____

Signature **Date**

Mailing List Authorization

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.

Payment Method

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

☐ Charge Card (MasterCard or VISA only) Amount to be charged: ____________

Account Number ________________________________ Exp. Date________________

Print Name on Card ________________________________ Signature ________________

Form D Professional Development Record

Instructions: Use this form to document your professional development requirements for your certification specialty. Keep copies of continuing education certificates for your records in case you are audited. List in-services, academic credits, CME credits, independent study that has been approved for continuing education and other continuing education related to the nursing specialty. If course titles do not clearly reflect the course's relevance to your practice, include a brief description of how the course impacts your practice.

NOTE: Before completing this form, review the Specific Eligibility Requirements for your specialty.

Candidate's Name (Last, First, MI) **Social Security Number**

Equivalencies:

1 CEU = 10 contact hours
1 contact hour = 50 minutes
1 academic quarter hour = 12.5 contact hrs
1 contact hour = 0.1 CEU
1 academic semester hour = 15 contact hours
1 CME = 60 minutes or 1.2 contact hours

Subject Matter/Course Content	Name of Sponsor, Provider or Institution	Date of Offering	Number of Contact/Academic Hours
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
		Total	

Specialty Nursing Certification (Read the statement below and then sign and date)

__ I hereby attest that I meet the eligibility criteria as stated in the most recent version of the catalog and ANCC website for the Pain Management certification exam. I have practiced the equivalent of 2 years full-time as a registered nurse in the United States or its territories. I have practiced the required hours as stated in the catalog for the specialty certification I am seeking. I have enclosed all forms and other documents as indicated for the specialty certification exam I am seeking.

Signature Date

American Nurses Credentialing Center
8515 Georgia Avenue • Suite 400 • Silver Spring, MD 20910
1-800-284-2378
www.nursecredentialing.org

PMC05 5/m 6/05