

# CARN-AP

Certified Addictions Registered Nurse - *Advanced Practice*

## Examination Application

*Includes Pages 10 - 17*

### INSTRUCTIONS:

Complete ALL sections of this application. Documents and payment must be mailed together to: **ANCB Examination Processing, C/O C-NET, 35 Journal Square, Suite 901 Jersey City, NJ 07306**

### Application Checklist:

*All items must be submitted together with certification fee*

- Signed Application Form
- Data Form
- Verification (**Forms A:** 500 clinical hrs. & **B:** 1,500 additional Hrs.)
- Continuing Education Form itemizing 45 contact hours
- Copy of diploma or transcript showing Master's in Nursing
- Copy of RN License showing expiration date
- A Copy of your current government issued photo ID

**Be advised: Incomplete applications are subject to an Incomplete Application Fee.**

### SECTION 1: CANDIDATE INFORMATION

To avoid additional fees you must complete ALL spaces in this section

**Be advised:** We will enter your name as it appears on your supplied government issued photo ID. The line below is for application processing only.

NAME \_\_\_\_\_  
Current Legal Last Name                      Maiden                      Legal First Name                      Middle Name

MAILING ADDRESS \_\_\_\_\_  
Street                      Apt#                      City                      State                      Zip

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER \_\_\_\_\_ E-MAIL \_\_\_\_\_  
*Your exam permit will be emailed to this email address*

CELL/ HOME PHONE NUMBER \_\_\_\_\_ WORK NUMBER \_\_\_\_\_

### SECTION 2: RN LICENSE

To avoid additional fees you must complete ALL spaces in this section

STATE: \_\_\_\_\_ PERMANENT NUMBER: \_\_\_\_\_

DATE OF ORIGINAL LICENSE: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

### SECTION 3: APPLICANT SIGNATURE

To avoid additional fees you must complete ALL spaces in this section

### APPLICANT: PLEASE READ AND SIGN THE STATEMENT OF UNDERSTANDING BELOW:

**Denial, Suspension, or Revocation of Certification.** The occurrence of any of the following actions will result in the denial, suspension, or revocation of Addictions Nursing Certification: (1) falsification of the CARN application; (2) falsification of any material information requested by the ANCB; (3) any restrictions such as revocation, suspension, probation, or other sanctions of professional RN license by nursing authority; (4) misrepresentation of CARN status; (5) cheating on the CARN examination.

#### STATEMENT OF UNDERSTANDING

I hereby attest that I have read and understand the Addictions Nursing Certification Board's policy of Denial, Suspension, or revocation of Certification and that its terms shall be binding on all applicants for certification and all certified addictions nurses for the duration of their certification. I hereby apply for certification offered by the Addictions Nursing Certification Board (ANCB). I understand that certification depends upon successful completion of the specified requirements. I further understand that the information accrued in the certification process may be used for statistical purposes and for evaluation of the certification program. I further understand that the information from my certification records shall be held in confidence and shall not be used for any other purpose without my permission. To the best of my knowledge, the information contained in this application is true, complete, correct, and is made in good faith. I understand that the ANCB reserves the right to verify any or all information on this application.

\_\_\_\_\_  
Legal Signature

\_\_\_\_\_  
Date

**SECTION 4: ADDITIONAL INFORMATION**

**INCOMPLETE STATUS**

To be considered "complete," an application must be submitted without missing documentation or requested information (this includes the correct payment). Incomplete applications are subject to a non-refundable incomplete application fee. To avoid additional charges, be sure to submit all items on the checklist (top of page 12) together with the application and check the application for all applicable signatures, dates, and information before submitting it to C-NET.

**CONTACT HOUR CERTIFICATES**

You are required to list all forty-five (45) contact hours of continuing education on the verification form supplied in this application. To reduce paper, please do not submit contact hour certificates. You should, however, be able to produce all contact hour certificates upon request, as random audits are routinely performed for compliance purposes.

**APPLICATION PROCESSING TIME**

Standard processing time for CARN-AP applications is four weeks from the time C-NET receives the application. If your application submission is incomplete, C-NET will notify you of your incomplete status by mail. C-NET is not responsible for US Postal Service delays. Additionally, if the applicant has not received any communication from C-NET within four weeks of the application postmark date, the applicant is responsible for informing C-NET immediately at info@cnetnurse.com.

**EXAMINATION PERMITS**

Examination permits will be emailed only to qualifying candidates. The permit will carry a 90-day testing window. You may schedule a test anytime during the 90-day window, but scheduling options may decrease the longer you wait to book your exam. C-NET does not handle computer-based exam scheduling by phone. All scheduling will be handled by you directly through the provided online link.

**SECTION 5: PAYMENT** Please enclose one of the following valid forms of payment. **Make checks payable to C-NET**

\$400.00 **STANDARD EXAM FEE**      Enclosed:  **Money Order/ Check**       **Credit Card** (Complete below)

\$350.00 **Membership Discount**

To receive a \$50 discount, applicants must attach proof of current membership to one of the following two organizations:

**ASAN                      or                      IntNSA (USA)**

Proof may include a membership card, certificate, or printed confirmation from an online account. Only one \$50 discount is allowed. Insufficient proof will result in the full exam fee being charged.

APPLICANT NAME \_\_\_\_\_

CARD HOLDER NAME  
(If different than above) \_\_\_\_\_

**Visa or Master Card Only:**

CARD NUMBER \_\_\_\_\_

Exp Date \_\_\_\_\_ Phone Number \_\_\_\_\_

**AUTHORIZATION**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE NOTE:** Your signature on this form acknowledges and authorizes the Center for Nursing Education and Testing (C-NET) to charge your credit card for a total of the amount indicated. Written refund requests shall be accepted by C-NET either: a) up to four (4) weeks after the application postmark date (or date received), or b) before the date the examination permit is issued (whichever comes first). The written request must be submitted by the purchaser and must include the applicant's full name, the last four digits of the social security number, and the name of the exam being canceled or the request will not be considered. All refunds are issued minus the application processing fee and any other non-refundable fees indicated in the application brochure or websites (cnetnurse.com). Refund requests received after the deadline will not be considered, and any fund received after the deadline shall become non-refundable and non-transferable.

Please complete the following items to provide important research data to the Addictions Nursing Certification Board. The information will be handled anonymously and will be used only for research to assist in the assessment to test validity.

----- DATA FORM -----

**Check your current position:**

- Administrator
- Nurse Manager
- Supervisor
- Clinical Nurse Specialist
- Researcher
- Educator
- Staff Nurse
- Nurse Practitioner (NP)
- Other

**Gender:**

- Male
- Female
- Other
- Prefer not to answer

**Ethnic Group:**

- American Indian or Alaska Native
- Asian (Indian Subcontinent)
- Other Asia (Far East, South East Asia)
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Hispanic/Latino
- White
- Other
- Prefer not to answer

**Years of RN experience:**

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- 31-35 years
- 36-40 years
- 41-45 years
- 46-50 years
- 51+ years

**Years of RN experience in addictions nursing:**

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- 31-35 years
- 36-40 years
- 41-45 years
- 46-50 years
- 51+ years

**Highest Level of Education:**

- Diploma in Nursing
- Associate's in Nursing
- Associate's - Other
- Bachelor's in Nursing
- Bachelor's - Other
- Master's in Nursing
- Master's - Other
- Doctorate in Nursing
- Doctorate - Other

**Current Practice Setting:**

- General Hospital
- Addictions Specialty Hospital/Unit
- Educational Institution
- Private Practice
- Free-Standing Facility
- Detoxification Unit
- Medication Management with Partial Agonist, Full Agonist and/or Antagonist Treatment
- Community Agency
- Other
- Currently Unemployed

**Currently certified in any other specialty:**

- No
- Yes

**Years in your current position?**

- Less than one year
- 1-3 Years
- 4-6 Years
- 7-10 Years
- More than 10 year

**What shifts do you usually work?**

- Days
- Evenings
- Nights
- Weekends

**Primary client problems you see (at least 25% of working hours):**

- Substance Use Treatment/Alcohol and Drug
- Dual Diagnosis
- Infectious Diseases
- Eating Disorders
- Gambling Disorder
- General Disorder
- Sexual Disorder
- Codependency/Family

**Age group you mostly work with:**

- Newborns
- Infants/Children
- Adolescents (age 12-20)
- Adults (age 21-64)
- Older Adults (age 65 and up)

**Current professional membership?**

- International Nurses Society on Addictions (IntNSA)
- State Nurses Association
- National League for Nursing
- Sigma Theta Tau International
- Other

**How did you hear about this certification?**

- Nursing Journal
- IntNSA Newsletter
- Colleague Marketing
- Marketing
- IntNSA Website
- Other Website
- Employer
- Other

## SECTION 7: REQUIREMENTS FOR VERIFICATION OF EXPERIENCE

### VERIFICATION OF EXPERIENCE

A total of 2000 hours (one year) of advance practice experience in addictions related practice are required for CARN-AP certification, with at least 500 of those hours being supervised clinical hours. To document this experience, two different Verification Forms have been provided.

They are: **Verification Form A: 500 Clinical Hours & Verification Form B: 1,500 Experience Hours**

#### VERIFICATION FORM A: 500 Supervised Clinical Hours

- ) Candidates applying to take the Certified Addictions Registered Nurse-Advanced Practice examination are required to provide documentation verifying a minimum of 500 hours of supervised, direct client contact in advanced clinical practice working with individuals and families impacted by addictions/dual diagnoses. All 500 hours must have been obtained within the **last four years**.
- ) Up to 500 hours may be earned while in a master's in nursing program. Candidates need not submit Verification Form A if all 500 hours were earned during a master's program.
- ) Candidates submitting hours from a master's program must provide a photocopy of the master's transcript; being sure to highlight any supervised clinical hours being submitted for consideration.
- ) Candidates submitting verification of 2000 (or more) hours on Verification Form A, need not submit Verification Form B.

#### VERIFICATION FORM B: 1,500 Additional Experience Hours

- ) Candidates are also required to have a minimum of **1500 hours** of nursing experience in addition as an Advanced Practice Nurse (APN). All 1,500 hours must have been obtained within the **last three years**.
- ) The accrued hours may be in a teaching, administrative, private practice, consultation, counseling, or research capacity.

#### VERIFICATION SIGNATURES FOR POST- MASTERS EXPERIENCE

It is **preferable** that the post-master's consultation/supervision be provided by a professional with experience and expertise in the field of addictions. The consulting/supervising professional may be one of the following:

- ) An addictions nurse specialist with a master's or higher degree and CARN or CARN-AP certification.
- ) A master's prepared licensed/certified mental health professional.
- ) A psychiatrist.
- ) A psychologist prepared at the doctoral level and listed in the National Registry of Health Service Providers in Psychology; or a psychologist prepared at the doctoral level in an American Psychological Association (APA)-accredited program in one of the following clinical areas: clinical psychology, counseling, or psychology.

THE FOLLOWING TWO PAGES CONTAIN VERIFICATION FORMS "A" AND "B". PLEASE CHECK ONE BOX BELOW TO INDICATE WHICH FORMS YOU ARE SUBMITTING WITH THIS APPLICATION:

- I am submitting only Verification Form "A" with this application**  
This option is for candidates who possess 2000 or more hours (one year) of supervised/clinical practice (in such cases Verification Form B is not required).
- I am submitting Verification Forms "A & B" with this application**  
This option is for candidates whose supervised clinical hours and non-clinical hours are all post-masters.
- In addition to Verification Form "B", I am submitting a Master's Transcript**  
This option is for candidates using 500 supervised clinical hours obtained during a master's program.
- In addition to Verification Forms "A & B", I am submitting a Master's Transcript**  
This option is for candidates whose 500 supervised clinical hours include a mix of both hours obtained during a master's program and post-masters.

This Verification Form is for candidates applying to take the Certified Addictions Registered Nurse-Advanced Practice examination; which is sponsored by the Addictions Nursing Certification Board. The verification should be completed and signed by the candidate's supervisor, and returned to the candidate. As part of the application process, the candidate must provide evidence of a minimum of **500 hours of supervised direct patient/client contact in advanced clinical practice** related to addictions. All required hours must have been accrued within the **last four years** to be deemed eligible for consideration. Candidates submitting hours from more than one employer may photocopy this form.

**----- VERIFICATION FORM A -----**  
**500 Supervised Clinical Hours**  
All sections below must be completed by supervisor

**PART 1** **APPLICANT NAME**  
I AM COMPLETEING THIS VERIFICATION FOR:

\_\_\_\_\_

Print first and last name of applicant applying for the CARN-AP exam.

**PART 2** **CLINICAL EXPERIENCE DATES**

**COMPLETE ALL BLANK FIELDS.** Check Here

The applicant's dates of experience were from:

START DATE: \_\_\_\_\_ END DATE: \_\_\_\_\_ If Currently Employed

Month \_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_ Year \_\_\_\_\_

Averaging \_\_\_\_\_ hours (per week) at this facility in **addictions nursing experience at the advanced practice level.**

**PART 3** **EXPERIENCE DESCRIPTION**  
Use this section if further explanation of the candidate's experience is required.

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**PART 4** **SUPERVISOR INFORMATION**

NAME: \_\_\_\_\_  
Print Name

Title: \_\_\_\_\_

Credentials (if any) \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

**PART 5** **FACILITY/SITE**

Practice Setting/Institution Name \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_

**PART 5** **SUPERVISOR SIGNATURE**

*I attest that the information provided on this page is, to the best of my knowledge, accurate:*

Signature: \_\_\_\_\_

Date \_\_\_\_\_

**SECTION 7b: VERIFICATION OF EXPERIENCE**

Photocopy this form if submitting hours from more than one employer

This Verification Form is for candidates applying to take the Addictions Nursing Certification Examination for Advanced Practice; which is sponsored by the Addictions Nursing Certification Board. The verification should be completed and signed by the candidate's supervisor, and returned to the candidate. As part of the application process, the candidate must have a minimum of **1500 hours** of nursing experience in addition as an Advanced Practice Nurse (APN). All 1,500 hours must have been obtained within the **last three years** to be deemed eligible for consideration. Candidates submitting hours from more than one employer may photocopy this form.

**----- VERIFICATION FORM B -----**  
**1,500 Hours of Additional Advanced Practice Experience**  
All sections below must be completed by supervisor

**PART 1** **APPLICANT NAME**

**I AM COMPLETEING THIS VERIFICATION FOR:**  
  
\_\_\_\_\_  
Print first and last name of applicant applying for the CARN-AP

**PART 2** **APN EXPERIENCE**

**COMPLETE ALL BLANK FIELDS.** Check Here   
The applicant's dates of experience were from:  
START DATE: \_\_\_\_\_ END DATE: \_\_\_\_\_ If Currently Working  
Month \_\_\_\_ Year \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_  
Averaging \_\_\_\_\_ hours (per week) at this facility in **addictions nursing experience at the advanced practice level.**

**EXPERIENCE HOURS WERE IN THE FOLLOWING CAPACITY (Check all that may apply):**

- Administrative       Consultation
- Research               Teaching
- Counseling             Private Practice
- Other (Please specify below)

**PART 3** **EXPERIENCE DESCRIPTION**

Use this section if further explanation of the candidate's experience is required.  
  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART 4** **SUPERVISOR INFORMATION**

NAME: \_\_\_\_\_  
Print Name  
  
Title: \_\_\_\_\_  
  
Credentials (if any) \_\_\_\_\_  
  
Phone \_\_\_\_\_  
  
Email \_\_\_\_\_

**PART 5** **FACILITY/SITE**

Practice Setting/Institution Name \_\_\_\_\_  
  
City \_\_\_\_\_ ST \_\_\_\_\_

**PART 5** **SUPERVISOR SIGNATURE**

*I attest that the information provided on this page is, to the best of my knowledge, accurate:*  
  
\_\_\_\_\_  
**Signature:**  
  
\_\_\_\_\_  
**Date**

**SECTION 8: VERIFICATION OF CONTINUING EDUCATION**

CARN-AP candidates must have a minimum of **forty-five (45)** contact hours in addictions nursing. At least 51% of those hours must be directly in addictions. The remaining hours may be related to addictions (HIV/AIDS, Hepatitis, pain management, pharmacology, symptom management, therapies used in addictions, motivational interviewing, etc.). All contact hours and the related information must be tallied **using this form** and must be applicable to addictions nursing. Actual continuing education certificates should **not be included** but must be made available upon request. These educational units must have occurred within the last **three (3) years**. If necessary, please make additional copies of page 19.

EXAMPLE

Hours Accrued | Date Completed: 06/21/21

Activity Sponsor: Medscape

Title of Program: Opioids in Suburban Populations

Type of Program: (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

Applicability to Addictions: (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

**VERIFICATION OF 45 CONTACT HOURS FOR CARN-AP**

To avoid additional fees, you must complete ALL spaces in this section.

Hours Accrued | Date Completed:  / /

Activity Sponsor: \_\_\_\_\_

Title of Program: \_\_\_\_\_

Type of Program: (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

Applicability to Addictions: (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

Hours Accrued | Date Completed:  / /

Activity Sponsor: \_\_\_\_\_

Title of Program: \_\_\_\_\_

Type of Program: (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

Applicability to Addictions: (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

Hours Accrued | Date Completed:  / /

Activity Sponsor: \_\_\_\_\_

Title of Program: \_\_\_\_\_

Type of Program: (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

Applicability to Addictions: (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

Hours Accrued | Date Completed:  / /

Activity Sponsor: \_\_\_\_\_

Title of Program: \_\_\_\_\_

Type of Program: (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

Applicability to Addictions: (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

TOTAL HOURS ON PAGE

**SECTION 8: VERIFICATION OF CONTINUING EDUCATION**

Photocopy this page as needed.

CARN-AP candidates must have a minimum of **forty-five (45)** contact hours in addictions nursing. At least 51% of those hours must be directly in addictions. The remaining hours may be related to addictions (HIV/AIDS, Hepatitis, pain management, pharmacology, symptom management, therapies used in addictions, motivational interviewing, etc.). All contact hours and the related information must be tallied **using this form** and must be applicable to addictions nursing. Actual continuing education certificates should **not be included** but must be made available upon request. These educational units must have occurred within the last **three (3) years**. If necessary, please make additional copies of this form.

**VERIFICATION OF 45 CONTACT HOURS FOR CARN-AP**

To avoid additional fees, you must complete ALL spaces in this section.

 Hours Accrued | Date Completed: \_\_\_ / \_\_\_ / \_\_\_

**Activity Sponsor:** \_\_\_\_\_

**Title of Program:** \_\_\_\_\_

**Type of Program:** (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

**Applicability to Addictions:** (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

 Hours Accrued | Date Completed: \_\_\_ / \_\_\_ / \_\_\_

**Activity Sponsor:** \_\_\_\_\_

**Title of Program:** \_\_\_\_\_

**Type of Program:** (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

**Applicability to Addictions:** (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

 Hours Accrued | Date Completed: \_\_\_ / \_\_\_ / \_\_\_

**Activity Sponsor:** \_\_\_\_\_

**Title of Program:** \_\_\_\_\_

**Type of Program:** (Choose One)

- Online home study, self-paced
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- In person seminar/conference

**Applicability to Addictions:** (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

 Hours Accrued | Date Completed: \_\_\_ / \_\_\_ / \_\_\_

**Activity Sponsor:** \_\_\_\_\_

**Title of Program:** \_\_\_\_\_

**Type of Program:** (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

**Applicability to Addictions:** (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

 Hours Accrued | Date Completed: \_\_\_ / \_\_\_ / \_\_\_

**Activity Sponsor:** \_\_\_\_\_

**Title of Program:** \_\_\_\_\_

**Type of Program:** (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

**Applicability to Addictions:** (Choose One)

- Directly in addictions (SUD, gambling, etc.)
- Related/co-occurring, (depression, HIV, PTSD, etc.)

 Hours Accrued | Date Completed: \_\_\_ / \_\_\_ / \_\_\_

**Activity Sponsor:** \_\_\_\_\_

**Title of Program:** \_\_\_\_\_

**Type of Program:** (Choose One)

- Online home study, self-paced
- Live webinar
- In person seminar/conference

**Applicability to Addictions:** (Choose One)

- Directly in addictions (SUD, gambling, etc.)
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 **TOTAL HOURS ON PAGE**