



CIC® RECERTIFICATION EXAMINATION APPLICATION

To order the CIC® recertification examination, complete the form below and submit it with the fee to the CBIC Executive Office, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823.

The CIC® recertification examination may be taken by the recertifying practitioner at his/her recertifying interval. To be considered for recertification, the recertification examination must be completed by December 31 of the recertifying year.

Fee: \$375 in U.S. funds

The deadline to purchase the recertification examination is December 20.

Please send me the link for the internet-based recertification examination to the following e-mail address (required) below. I have enclosed payment in U.S. funds for the fee listed below.

PRINT NAME		
Last:	First:	MI:
Designation(s):	Current Title:	Certification # (if known):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: Mo: ____ Day: ____ Yr: ____		
HOME MAILING ADDRESS <input type="checkbox"/> preferred		
Street/P.O. Box:		City:
State/Province:	Country:	Zip/Postal Code:
Daytime Telephone No.:	Evening Telephone No.:	Fax No.:
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BUSINESS ADDRESS <input type="checkbox"/> preferred		
Organization Name:		
Street/P.O. Box:		City:
State/Province:	Country:	Zip/Postal Code:
Business Telephone No.:	Business Fax No.:	Email: (required)
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PLEASE PROVIDE THE FOLLOWING INFORMATION:		PROFESSIONAL LICENSE OR REGISTRATION/CERTIFICATION:
Education level (choose highest level):		(choose up to two)
<input type="checkbox"/> Associate's Degree in Nursing		<input type="checkbox"/> LPN or RPN Year obtained: _____
<input type="checkbox"/> Bachelor's Degree in Nursing		<input type="checkbox"/> Medical Technologist Year obtained: _____
<input type="checkbox"/> Bachelor's degree (other/non-Nursing)		<input type="checkbox"/> Physician Year obtained: _____
<input type="checkbox"/> Master's degree in:		<input type="checkbox"/> Registered Nurse Year obtained: _____
<input type="checkbox"/> Nursing		<input type="checkbox"/> Respiratory Therapist Year obtained: _____
<input type="checkbox"/> Microbiology		<input type="checkbox"/> Other (specify) Year obtained: _____
<input type="checkbox"/> Medical Technology		_____
<input type="checkbox"/> Doctorate in Nursing		<input type="checkbox"/> None
<input type="checkbox"/> Doctorate in Medicine		
Specialty: _____		

PRACTICE SETTING:

(Please choose at least one of the following:)

- Ambulatory Care
- Acute Care/Hospital
- Behavioral Health
- EMS/Public Health

- Home Care
- Long-Term Care
- Veteran Affairs
- Self-Employed/Consultant
- Other: _____

Year Started in Infection Prevention and Control: _____

PROFESSIONAL ORGANIZATIONS

If you're not a member of APIC or IPAC Canada and would like more information, please check this box:

Recertification Examination: \$375

Method of Payment: Check payable to CBIC* VISA** MasterCard** American Express** Discover**

Account Number:

Expiration Date:

Cardholder's Name (please print):

Signature:

* A charge of \$20 will apply to checks returned for insufficient funds.
 ** If rebilling of a credit card charge is necessary, a \$25 processing fee will be charged.

Please return this form with payment to:
 Examination Services
 CBIC
 555 East Wells Street
 Suite 1100
 Milwaukee, WI 53202-3823
 Fax: 414/276-3349

Within two weeks of application submission, the recertification candidate will receive a confirmation email with specific instructions on how to access their internet-based recertification examination. This email will include a unique candidate ID that must be used each time the candidate signs into their examination. Candidates are able to log into and out of their examination as many times as is necessary, within the established testing window, to complete the examination; responses provided during previous sessions will be saved. Candidate pass/fail results are provided immediately onscreen after submission of the examination and completion of the post-examination survey. A score report will also be mailed to the candidate two to four weeks after exam submission. The recertification examination must be completed by December 31. All incomplete examinations will be automatically submitted for scoring at 11:59pm GMT.

NOTIFICATION OF SUPERVISOR

If you pass the CIC* exam, who would you like us to contact? (e.g., supervisor, director, CNO, etc.)

Last: _____ First: _____ MI: _____

Designation(s): _____ Current Title: _____

Organization Name: _____

Street/P.O. Box: _____ City: _____

State/Province: _____ Country: _____ Zip/Postal Code: _____

Daytime Phone No.: _____ Evening Telephone No.: _____ Email: (required)
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If you do not want CBIC to notify anyone, please check here