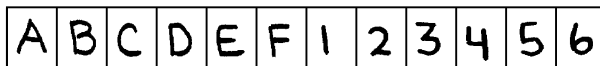


Testing Center Application for National Board Certification for

CERTIFIED WOUND SPECIALIST

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided. →



Candidate Information

First Name Middle Name

--	--

Last Name

--

Number and Street Apartment Number

--	--

City State/Province Zip/Postal Code

--	--	--

Daytime Phone Evening Phone

	-		-		-	
--	---	--	---	--	---	--

Email Address

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Testing Period: Spring Fall

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. WHAT IS YOUR PROFESSIONAL DESIGNATION?

- Registered Nurse
- Physical Therapist
- Physician's Assistant
- Occupational Therapist
- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Researcher
- Other (specify) _____

B. HOW LONG HAVE YOU BEEN EMPLOYED IN THE FIELD OF WOUND MANAGEMENT?

- 3 to 5 years More than 10 years
- 6 to 10 years

C. HIGHEST ACADEMIC LEVEL:

- Bachelor's Degree Doctoral Degree
- Master's Degree Other

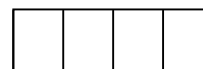
D. WHAT PERCENTAGE OF YOUR WORKDAY INVOLVES WOUND CARE?

- Less than 10% 50% to 74%
- 10% to 24% 75% to 99%
- 25% to 49% 100%

E. PRIMARY PRACTICE CENTER: (Darken one response)

- Hospital Educational Institution
- Long-term Care Facility Industry
- Home Health Government Agency
- Wound Care Center Other (specify below) _____
- Private Practice

(Continue on page 2)



Testing Center Application for National Board Certification for

CERTIFIED WOUND SPECIALIST

Eligibility and Background Information

F. WHAT IS THE PRIMARY REASON YOU WISH TO BECOME CERTIFIED? *(Darken only one response.)*

- Required by current employer
- Personal choice/professional pride
- Preparation for seeking new position in wound management
- To qualify for a salary increase
- To qualify for a higher position with current employer
- Required by profession
- Other (specify) _____

G. HAVE YOU TAKEN THIS EXAMINATION BEFORE?

- No Yes

If yes, indicate month, year, and name under which the examination was taken.

Date (month/year): _____

Name: _____

Optional Information

Note: Information related to ethnicity, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your eligibility or test results.

Ethnicity:

- African American Native American
- Asian White
- Hispanic Other

Age Range:

- Under 25 40 to 49
- 25 to 29 50 to 59
- 30 to 39 60+

Gender:

- Male
- Female

Certificate Name

Please print your name and credentials on the line below exactly as you would like it to appear on your certificate.

Name and Credentials (please print)

Candidate Signature

I have read the Handbook for Candidates and understand I am responsible for knowing its contents. I certify that the information given in this Application is in accordance with Handbook instructions and is accurate, correct, and complete.

CANDIDATE SIGNATURE: _____ **DATE:** _____

Office Use			
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9
0	0	0	0

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