



# Application for National Board Recertification Examination For Certified Wound Specialists™

## Applicant Information *(PLEASE PRINT OR TYPE)*

1. Name \_\_\_\_\_
2. Maiden Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
(This is to speed the application process and for the purpose of verifying college transcripts, licenses, etc.)
3. Organization or Employer/Affiliation \_\_\_\_\_
4. Permanent Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
5. Phone/Office \_\_\_\_\_ 6. Phone/Home \_\_\_\_\_ 7. Cell \_\_\_\_\_
8. E-mail \_\_\_\_\_

## Recertification Application Checklist

- PTC Testing Center Application signed and completed
- Check or money order for \$550.00 issued to the American Academy of Wound Management

If paying by credit card please complete the following information:

Please charge \$ \_\_\_\_\_ to my:  American Express  Master Card  Visa

Credit Card Account # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



Name (Please print) \_\_\_\_\_

I hereby apply to the American Academy of Wound Management (the "AAWM") for examination and issuance to me of certification as a Certified Wound Specialist™ ("CWS™") in accordance with and subject to the procedures and regulations of the AAWM. I have read and agree to the conditions set forth in the AAWM's Handbook for Candidates covering eligibility, the administration of the Certification Examination; the certification process; and AAWM's rules and policies. I agree to disqualification from examination; to denial, suspension, or revocation of certification; and to forfeiture and redelivery of any certificate or other credential granted me by the AAWM in the event that any of the statements or answers made by me in this application are false or in the event that I violate any of the rules or regulations governing such examination.

I authorize the AAWM to make whatever inquiries and investigations it deems necessary to verify my credentials and my professional standing. I understand that this application and any information or material received or generated by the AAWM in connection with my examination and/or certification will be kept confidential and will not be released unless I have authorized such release or such release is required by law. However, the fact that I am or am not, or have or have not been, certified is a matter of public record and may be disclosed. Finally, I allow the AAWM to use information from my application and subsequent examination for the purpose of statistical analysis, provided that my personal identification with that information has been deleted.

I understand that the content of the Certification Examination is proprietary and strictly confidential information. I hereby agree that I will not disclose, or assist in the disclosure of, either directly or indirectly, any question or any part of any question from an examination to any person or entity. I understand that I may be disqualified from taking or continuing to sit for an examination, or from receiving examination scores, if the AAWM determines through either proctor observation, statistical analysis, or any other means that I was engaged in collaborative, disruptive, or other unacceptable behavior before, during the administration of, or following the Certification Examination.

I further understand that the unauthorized receipt, retention, possession, copying or disclosure of any examination materials, including but not limited to the content of any examination question, before, during, or after the examination may subject me to legal action resulting in monetary damages and/or disciplinary action resulting in denial or revocation of certification.

I hereby agree to hold the AAWM, its officers, directors, examiners, employees, and agents, harmless from any complaint, claim, or damage arising out of any action or omission by any of them in connection with this application, the application process, any examination given by the AAWM, any grade relating thereto, the failure to issue me any certificate, or any demand for forfeiture or redelivery of such certificate.

**I UNDERSTAND THAT THE INITIAL DECISION AS TO WHETHER I QUALIFY FOR CERTIFICATION, AND ALL FUTURE DECISIONS REGARDING MY CONTINUED QUALIFICATION FOR CERTIFICATION, REST SOLELY AND EXCLUSIVELY WITH THE AAWM AND THAT THE DECISIONS OF THE AAWM ARE FINAL.**

**I HAVE READ AND UNDERSTAND THESE STATEMENTS AND I INTEND TO BE LEGALLY BOUND BY THEM.**

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

Date: \_\_\_\_\_

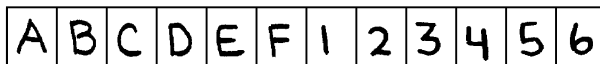
**Send Application to:**

1155 15th Street NW • Suite 500 • Washington, DC • 20005 • Ph: 202-457-8408 • Fx: 202-530-0659 • info@aawm.org  
www.aawm.org

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

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Last Name

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Number and Street Apartment Number

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City State/Province Zip/Postal Code

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Daytime Phone Evening Phone

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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

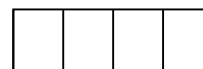
**D. WHAT PERCENTAGE OF YOUR WORKDAY INVOLVES WOUND CARE?**

- 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)*



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# 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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