

# Testing Center Application for National Board Certification for CERTIFIED WOUND CARE ASSOCIATE

**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. →

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## Candidate Information

First Name	<table border="1" style="width: 100%; height: 25px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																					Middle Name	<table border="1" style="width: 100%; height: 25px;"><tr><td></td></tr></table>																																								
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Testing Period: <input type="radio"/> Summer (August) <input type="radio"/> Winter (February)																																																															

## Eligibility and Background Information

*Darken only one choice for each question unless otherwise directed.*

<p><b>A. WHAT IS YOUR PROFESSIONAL DESIGNATION?</b></p> <p><input type="radio"/> Registered Nurse</p> <p><input type="radio"/> Licensed Practical Nurse or Licensed Vocational Nurse</p> <p><input type="radio"/> Physical Therapist Assistant</p> <p><input type="radio"/> NonClinical</p> <p><input type="radio"/> Researcher</p> <p><input type="radio"/> Other (specify) _____</p> <p><b>B. HOW LONG HAVE YOU BEEN EMPLOYED IN THE FIELD OF WOUND MANAGEMENT?</b></p> <p><input type="radio"/> 3 to 5 years                      <input type="radio"/> More than 10 years</p> <p><input type="radio"/> 6 to 10 years</p>	<p><b>C. HIGHEST ACADEMIC LEVEL:</b></p> <p><input type="radio"/> High School Graduate or Equivalent    <input type="radio"/> Bachelor's Degree</p> <p><input type="radio"/> Some College                                      <input type="radio"/> Master's Degree</p> <p><input type="radio"/> Professional Diploma or Certificate    <input type="radio"/> Doctoral Degree</p> <p><input type="radio"/> Associate's Degree                                      <input type="radio"/> Other</p> <p><b>D. WHAT PERCENTAGE OF YOUR WORKDAY INVOLVES WOUND CARE?</b></p> <p><input type="radio"/> Less than 10%                      <input type="radio"/> 50% to 74%</p> <p><input type="radio"/> 10% to 24%                              <input type="radio"/> 75% to 99%</p> <p><input type="radio"/> 25% to 49%                              <input type="radio"/> 100%</p> <p><i>(Continue on page 2)</i></p>
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Testing Center Application for National Board Certification for

# CERTIFIED WOUND CARE ASSOCIATE

## Eligibility and Background Information

**E. PRIMARY PRACTICE CENTER:** *(Darken one response)*

- |   |   |
|---|---|
| <input type="radio"/> Hospital                | <input type="radio"/> Educational Institution |
| <input type="radio"/> Long-term Care Facility | <input type="radio"/> Industry                |
| <input type="radio"/> Home Health             | <input type="radio"/> Government Agency       |
| <input type="radio"/> Wound Care Center       | <input type="radio"/> Other (specify below)   |
| <input type="radio"/> Private Practice        | _____   |

**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:**

- |  |                                       |
|--|---------------------------------------|
| <input type="radio"/> African American | <input type="radio"/> Native American |
| <input type="radio"/> Asian            | <input type="radio"/> White           |
| <input type="radio"/> Hispanic         | <input type="radio"/> Other           |

**Age Range:**

- |                                |                                |
|--------------------------------|--------------------------------|
| <input type="radio"/> Under 25 | <input type="radio"/> 40 to 49 |
| <input type="radio"/> 25 to 29 | <input type="radio"/> 50 to 59 |
| <input type="radio"/> 30 to 39 | <input type="radio"/> 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:** \_\_\_\_\_

