Testing Center Application for National Board Certification for

WOUND MANAGEMENT PROFESSIONALS

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.

A B C D E F 1 2 3 4 5 6

Candidate Information																					
Print your LAST NAME then FIRST NAME then MIDDLE INITIAL																					
Number and Street											Apartment Number										
City State/Province Zip/Posta											ostal	Code									
Dayti	Daytime Phone Evening Phone																				
] -				–							-] -				
Email Address																					
Testing Center Number (See Handbook)																					
City: State:																					
Elig	Eligibility and Background Information																				

Darken only one choice for each question unless otherwise directed.

Α.	WHAT IS YOUR PRO	FESSIONAL DESIGNATION?	C .	2. HIGHEST ACADEMIC LEVEL:						
	○ Registered Nurse			🔿 High School Gradua	te or Equivaleı	alent O Bachelor's Degree				
	O Physical Therapist			○ Some College		○ Master's Degree				
	O Licensed Practical Nu	rse or Licensed Vocational Nurse		O Professional Diplom	e 🔿 Doctoral Degree					
	O Physician's Assistant			O Associate's Degree	O Other					
	O Occupational Therapi	st								
	O Physical Therapist As	sistant	D.	WHAT PERCENTAGE OF YOUR WORKDAY INVOLVES						
	O Doctor of Medicine			WOUND CARE?						
	O Doctor of Osteopathy			O Less than 10%	74%					
	O Doctor of Podiatric M	edicine		 ○ 10% to 24% ○ 75% to 99 ○ 25% to 49% ○ 100% 		99%				
	O Nonclinical			○ 25% to 49%						
	O Researcher		E.	PRIMARY PRACTICE CENTER: (Darken one response)						
	O Other (specify)		E .	_	_	\bigcirc Educational Institution				
				O Hospital		-				
В.		OU BEEN EMPLOYED IN THE		O Long-term Care Facility						
	FIELD OF WOUND N			O Home Health		Government Agency				
	O Less than 2 years	○ 6 to 10 years		O Wound Care Center	0	Other (specify below)				
	🔿 2 to 5 years	○ More than 10 years		O Private Practice	_					
			(Continue on page 2)							



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Eligibility and Background Information F. WHAT IS THE PRIMARY REASON YOU WISH TO G. DO YOU LIVE IN THE STATE WHERE YOU PRACTICE? BECOME CERTIFIED? (Darken only one response.) O No O Yes O Required by current employer If no, please specify state of practice: O Personal choice/professional pride O Preparation for seeking new position in wound H. HAVE YOU TAKEN THIS EXAMINATION BEFORE? management O No O Yes O To qualify for a salary increase If yes, indicate month, year, and name under which the O To qualify for a higher position with current examination was taken. employer Date (month/year):_ O Required by profession O Other (specify) 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: O African American O Native America O Asian O White O Hispanic O Other	Age Range: O Under 25 0 40 to 49 O 25 to 29 0 50 to 59 O 30 to 39 0 60 +	Gender: O Male O Female
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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: -





