Testing Center Application for National Board Certification for

WOUND CARE ASSOCIATES

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

First Name | Middle Name

Last Name

Number and Street | Apartment Number

City | State/Province | Zip/Postal Code

Daytime Phone - -

Evening Phone - -

Fax - -

Email Address

Testing Period: ○ Summer (August) ○ Winter (February)

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. WHAT IS YOUR PROFESSIONAL DESIGNATION?

- ○ Registered Nurse
- ○ Physical Therapist
- ○ Licensed Practical Nurse or Licensed Vocational Nurse
- ○ Physician's Assistant
- ○ Occupational Therapist
- ○ Physical Therapist Assistant
- ○ Doctor of Medicine
- ○ Doctor of Osteopathy
- ○ Doctor of Podiatric Medicine
- ○ Nonclinical
- ○ Researcher
- ○ Other (specify) _____

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

- ○ Less than 2 years
- ○ 2 to 5 years
- ○ 6 to 10 years
- ○ More than 10 years

C. HIGHEST ACADEMIC LEVEL:

- ○ High School Graduate or Equivalent
- ○ Some College
- ○ Professional Diploma or Certificate
- ○ Associate's Degree
- ○ Bachelor's Degree
- ○ Master's Degree
- ○ Doctoral Degree
- ○ Other

D. WHAT PERCENTAGE OF YOUR WORKDAY INVOLVES WOUND CARE?

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

(Continue on page 2)

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

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

_____

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. DO YOU LIVE IN THE STATE WHERE YOU PRACTICE?

○ No ○ Yes

If no, please specify state of practice: _____

H. 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
- ○ Asian
- ○ Hispanic
- ○ Native American
- ○ White
- ○ Other

Age Range:

- ○ Under 25
- ○ 25 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 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:*** _____