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.

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Eli	gibility and Ba	ckground Informa	tion			
E.	PRIMARY PRACTI	CE CENTER: (Darken o	ne response)	G.	DO YOU LIV	VE IN THE STATE WHERE YOU PRACTICE?
	O Hospital	O Educational	Institution		O No O	Yes
	O Long-term Care Fa	cility O Industry			If no, please s	specify state of practice:
	O Home Health	O Governmen	t Agency		HAVE VOL	TAKEN THE EVANGUATION REFORES
	O Wound Care Cente		• .	H.		TAKEN THIS EXAMINATION BEFORE? Yes
	O Private Practice					e month, year, and name under which the
					examination v	
	BECOME CERTIFI O Required by cu O Personal choice O Preparation for management O To qualify for a employer O Required by pr O Other (specify)	e/professional pride r seeking new position in a salary increase a higher position with corofession	in wound urrent	Nueste de la companya della companya della companya de la companya de la companya della companya	Name:	in complying with general guidelines pertaining to
						your eligibility or test results.
Et C	thnicity: O African American O Asian O Hispanic	Native AmericanWhiteOther	Age Range: O Under 25 O 25 to 29 O 30 to 39	0	40 to 49 50 to 59 60+	Gender: O Male O Female
	ertificate Name					
Plea	ase print your name and	credentials on the line belo	w exactly as you wo	ould lik	e it to appear o	n your certificate.
Nar	ne and Credentials (plea	se print)				
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