To apply online, visit www.goHPCC.org.
To apply using this form, provide the requested information and mail it to be RECEIVED by AMP by the paper application deadline. Applications received after the deadline or postmarked on the deadline will be returned unprocessed. FAXED APPLICATIONS ARE NOT ACCEPTED. Read the Candidate Handbook before completing this application. Mail the completed application and payment made by credit card, personal check, cashier’s check or money order payable to HPCC to: HPCC Certification Examination, AMP, 18000 W. 105th St., Olathe, KS 66061-7543.

1. Personal Information (please print using blue or black ink)

   Last Name: ____________________________
   First Name: ____________________________
   Middle Initial: ____________________________
   Former Name (if applicable): __________
   Date of Birth (xx/xx/xxxx): __________
   Applicant Email Address: ____________________________

Your HOME Information

   Address Line 1: ____________________________
   Address Line 2: ____________________________
   City: ____________________________
   State/Province: ____________________________
   Zip/Postal Code: ____________________________
   Country: ____________________________
   Home Phone: ____________________________
   Cell Phone: ____________________________

2. I am a:
   ☐ New Applicant (not currently certified at this level)
   ☐ Reapplicant (previously attempted this examination and have not previously held this certification)
   ☐ Applicant for Renewal (currently certified at this level)
   ☐ I am including a Special Examination Accommodations Request. Please include completed form at end of handbook.

3. Eligibility and Examination Fees

   Persons applying for a certification examination who are current HPNA members PRIOR to applying for the Certification Examination are entitled to the HPNA member discounted examination fee as a membership benefit. Must include HPNA membership to receive discount.

   HPNA membership number ____________________________.
   HPCC certification number (for renewal) ____________________________.

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<th>Certification</th>
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<td>Perinatal Loss Care Examination</td>
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Payment Information: Please indicate your method of payment.
   ☐ Check or money order (personal or cashier’s check payable to HPCC)
   ☐ Credit card: If payment is made by credit card, please provide the following information.
   ☐ MasterCard       ☐ VISA       ☐ AMEX       ☐ Discover

   Account Number ____________________________
   Expiration Date (MM/YY) ____________________________
   Security Code ____________________________

   Name as it Appears on Card ____________________________
   Signature ____________________________
Demographic Information – Please complete the following demographic questions. Select only one response for each question, unless directed otherwise.

1. Which of these best describes the nature of your practice? (check one)
   - Hospice care
   - Palliative care
   - Both

2. Total number of years in your profession?
   - 0-2 years
   - 3-5 years
   - 6-10 years
   - 11-15 years
   - 16-20 years
   - 21-25 years
   - 26-30 years
   - More than 30 years

3. Total number of years in hospice and palliative care?
   - 0-2 years
   - 3-5 years
   - 6-10 years
   - 11-15 years
   - 16-20 years
   - 21-25 years
   - 26-30 years
   - More than 30 years

4. Which of the following is your primary employer? (check one)
   - Hospice agency
   - Home health agency
   - Hospital or healthcare system
   - Long-term care facility
   - College or university
   - Self (private practice)
   - Private physician practice
   - Ambulatory care facility
   - Correctional facility

5. What is your primary practice setting? (check one)
   - Private home
   - Nursing home, assisted living or extended care facility
   - Hospital: palliative care unit
   - Hospital: hospice unit
   - Hospital: other unit or scattered beds
   - Freestanding residential or inpatient hospice
   - Any setting in which patient resides
   - Clinic
   - Prison
   - I do not routinely see patients

6. Type of practice
   - Clinical
   - Educational
   - Administrative
   - Research

7. What is your primary role?
   - Staff nursing assistant
   - Staff nurse (RN, LPN/LVN)
   - Clinical supervisor/patient care coordinator
   - Manager/administrator
   - Clinical educator (including staff development)
   - Advanced practitioner (i.e., CNS, NP)
   - Consultant for hospice/palliative care team
   - Faculty/researcher

8. What is the highest academic level you have attained?
   - High school diploma
   - CNA-state
   - Associate degree in nursing
   - Diploma in nursing
   - Bachelor’s degree (non-nursing)
   - Bachelor’s degree (nursing)
   - Master’s degree (non-nursing)
   - Master’s degree (nursing)
   - Doctoral degree (nursing)
   - Doctoral degree (non-nursing)

9. Primary age group served
   - Adult
   - Pediatric

10. Gender (optional)
    - Male
    - Female

11. Race (optional)
    - African American/Black
    - Asian/Asian American/Pacific Islander
    - Caucasian
    - Hispanic
    - Native American/Alaskan Native
    - Multiracial
    - Other

12. Credentials: __________________________

13. Employer Name (required): If you are not currently employed, please enter ‘none.’
    __________________________

14. Street Address: __________________________

15. City: __________________________

16. State: __________________________

17. Zip Code: __________________________
Attestation and Signature (Sign and date in ink the statement below.)
I certify that I have read all portions of the Candidate Handbook and application, and I agree to all terms of the HPCC processing agreement. I certify that the information I have submitted in this application and the documents I have enclosed are complete and correct to the best of my knowledge and belief. I understand that, if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed or voided, not released or invalidated by HPCC.

Audits of HPCC Applications – To ensure the integrity of eligibility requirements, HPCC will audit a percentage of randomly selected applications each year. Candidates whose applications are selected for audit will be notified and required to provide documentation of their professional license and verification of practice hours.

Please check below to confirm you currently meet the eligibility requirements for the examination you are registering for:

**Advanced Practice Registered Nurse Examination**
- I am currently licensed as a registered nurse in the United States, its territories or the equivalent in Canada.
- Nurse Practitioner
- Clinical Nurse Specialist
- I have worked as an advanced practice registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

**Registered Nurse Examination**
- I am currently licensed as a registered nurse in the United States, its territories or the equivalent in Canada.
- I have worked as a registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

**Pediatric Registered Nurse Examination**
- I am currently licensed as a registered nurse in the United States, its territories or the equivalent in Canada.
- I have worked as a pediatric registered nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

**Licensed Practical/Vocational Nurse Examination**
- I am currently licensed as a licensed practical/vocational nurse in the United States or its territories.
- I have worked as a licensed practical/vocational nurse in hospice and palliative care for at least 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application.

**Nursing Assistant Examination**
- I have fulfilled the eligibility requirement of 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months prior to submission of this application in hospice and palliative nursing assistant practice under the supervision of a registered nurse.

**Administrator Examination**
- I have fulfilled the eligibility requirements of the equivalent of two years of full time hospice and palliative administrative work in the past three years that encompasses the content in the Administrator test content outline prior to submission of this application.

**Perinatal Loss Care Examination**
- I hold a professional degree and I am currently licensed in the United States or its territories as
  - Registered Nurse
  - Physician
  - Psychologist
  - Counselor
  - Child Life Specialist
  - Social Worker
  - Chaplain
- I have fulfilled the eligibility requirement working in my profession and the area of perinatal loss and/or bereavement support for a minimum of two years in the past three years prior to submission of this application.
Within the last five (5) years:

- [ ] [ ] Have you ever been sued by a patient?
- [ ] [ ] Have you ever been found to have committed negligence or malpractice in your professional work?
- [ ] [ ] Have you ever had a complaint filed against you before a governmental regulatory board or professional organization?
- [ ] [ ] Have you ever been subject to discipline, certificate or license revocation, or other sanction by a governmental regulatory board or professional organization?
- [ ] [ ] Have you ever been the subject of an investigation by law enforcement?
- [ ] [ ] Have you ever been convicted of, pled guilty to, or pled nolo contendere to a felony or misdemeanor, or are any such charges pending against you?

I further affirm that no licensing authority has taken any disciplinary action in relation to my license to practice in the aforementioned or any other state, and that my license to practice has not been suspended or revoked by any state or jurisdiction.

No refunds will be issued once payment is processed.

Name (Please Print) ______________ Signature ______________ Date ______________

HPCC reserves the right to contact you for further information as deemed necessary.