Continuing Education Record

Use this form to document 54 hours of continuing education in nursing, with 18 specific to correctional health care, within the last 3 years. Keep copies of continuing education certificates for your records in case you are audited. Examples: in-services, academic credits, CME credits, independent study that has been approved for continuing education, and continuing nursing education related to correctional health care. If course titles do not clearly reflect the course’s relevance to correctional health care, include a brief description of how the course relates.

**Equivalencies:**

- 1 CEU = 10 contact hours
- 1 contact hour = 0.1 CEU
- 1 contact hour = 60 minutes
- 1 academic semester hour = 15 contact hours
- 1 academic quarter hour = 12.5 contact hrs
- 1 CME = 60 minutes or 1 contact hour

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<tr>
<th>Course Title: If the title does not clearly reflect the content, provide a brief description</th>
<th>Name of Sponsor, Provider or Institution</th>
<th>Date of Offering</th>
<th>Number of Contact Hours</th>
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**Total:**

54 contact hours required
Check all degrees you have been awarded (do not include high school).

- AAS  Associate of Applied Science
- AAN  Associate of Arts in Nursing
- ADN  Associate Degree in Nursing
- BA   Bachelor of Arts
- BN   Bachelor of Nursing
- BSN  Bachelor of Science in Nursing
- BS   Bachelor of Science in Other Field
- DN   Doctor of Nursing
- DNP  Doctor of Nursing Practice
- DrNP Doctor of Nursing Practice
- DNS  Doctor of Nursing Science
- EdD  Doctor of Education
- MA   Master of Arts
- MBA  Master of Business Administration
- MN   Master of Nursing
- MPH  Master of Public Health
- MSN  Master of Science in Nursing
- MS   Master of Science in Other Field
- PhD  Doctorate in Nursing
- PhD  Doctorate in Other Field

Other:   ________________________________

Required attachment: Photocopy of license

Current RN License Number

State   Expiration Date (month/date/year)

I hereby apply for CCHP-RN certification offered by the CCHP Board of Trustees (CCHP Board). I understand that I am subject to all requirements of certification as described in this application and that certification depends on successfully completing specified program requirements. I authorize the CCHP Board to make whatever inquiries and investigations that it deems necessary to verify my credentials and professional standing. To the best of my knowledge, the information on this application is true, complete, and correct. I attest by my signature that I meet the eligibility criteria as stated in this application and on the CCHP Web site: www.ncchc.org/cchpm.

I attest by my signature that I will maintain an active registered nurse licensure throughout the entire period during which I am certified. I understand that any misstatement of any material fact submitted upon application for certification may be sufficient cause for the CCHP Board to bar me from the examination, to invalidate the results of my examination, to withhold certification, to revoke certification, or to take other appropriate action.

(Applications received without a signature incur a delay in processing which will cause a delay in the review of your application and ability to take the CCHP-RN examination.)

Required Signature  Print Name  Date
Demographic and Employment Information

1. Location of facility:
   - Urban
   - Rural
   - Suburban
   - Outside the U.S.

2. Will you receive a monetary reward/compensation from your employer for certification?
   - Yes
   - No. If yes,
     - $ __________/per hour
     - $ __________/per year
     - $ __________ one time

3. Years of experience as a registered nurse (round to nearest whole year): ________________

4. Total years of experience in correctional health care (round to nearest whole year): __________

5. Primary place of employment (check one):
   - County or city jail
   - Department of health
   - Federal prison
   - Hospital (community)
   - Immigration and customs (ICE)
   - State DOC headquarters
   - State juvenile facility
   - State prison
   - Other: ________________________________

6. Average number of hours worked per week
   - 8 or fewer
   - 9-16
   - 17-24
   - 25-32
   - 33-40
   - >40

7. Size of facility (ADP):
   - N/A
   - 1-250
   - 251-500
   - 501-1000
   - >1000

8. Is certification part of your employer’s job performance rating criteria?
   - Yes
   - No

9. How did you obtain this application?
   - From NCCHC/CCHP website
   - Mailed from NCCHC/CCHP
   - From my workplace
   - At a tradeshow
   - Other: ________________________________

Other Demographic Information
Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Gender: □ M □ F

Race/Ethnic Group:
   - American Indian/Alaska Native
   - Native Hawaiian
   - Asian/Pacific Islander
   - White/Caucasian
   - Black/African-American
   - Other: ________________________________
   - Hispanic

Date of Birth: ____________________________ month/date/year
To Do List

DATE COMPLETED

_______________ Read this entire application, front to back.

_______________ Determine whether you are/when you will be eligible to take the exam.

_______________ Complete any missing requirements such as practice hours or continuing education hours.

_______________ Download the full length Test Content Outline and Reference List for this exam at the CCHP Web site: www.ncchc.org/cchprn. These documents are used to create the exam.

STUDY PLAN

Before taking the exam, develop a study plan. This might include self study, finding a study buddy or group, taking a review course, reviewing current textbooks and articles, or other methods. The key is to have a study plan and follow through with it.

_______________ Review the sample test questions on the CCHP Web site at www.ncchc.org/cchprn.

FILL OUT THE APPLICATION

At least two months before you plan to take the exam, fill out the application, attaching all required attachments.

Required attachments:
• Photocopy of nursing license
• Payment (if paying by check or money order)

Attachments for special circumstances:
Those requesting special accommodations under the Americans with Disabilities Act (ADA) must submit the special accommodations form found on our Web site: www.ncchc.org/cchprn.

MAIL APPLICATION

Mail your application and attachments to:

CCHP Board of Trustees
1145 W Diversey Pkwy
Chicago, IL 60614

Within three weeks from the date you mail your application, you will receive a Receipt of Application Notice in the mail. If you do not, contact us at cchp@ncchc.org or 773.880.1460.

Within six weeks from the date you mailed your application, you will receive either an Eligibility Notice or a letter requesting additional information. Your Eligibility Notice will give you 1 year during which to schedule and take your exam. Read it carefully and follow directions.

RESULTS

After you have taken your exam, you will receive your results within eight weeks. If you passed, you will receive a certificate and pin. Certification is renewable annually.

After you pass the exam, download the Certification Renewal materials from the CCHP Web site at www.ncchc.org/cchprn and begin tracking your renewal requirements.