2024 HPCC NURSE RETEST ASSURED PROGRAM REGISTRATION

Directions: Unsuccessful candidates may use this form to register for the reTEST Assured Program, provided they meet HPCC's eligibility criteria at the time of submission.

Complete the requested information and email it to be RECEIVED by PSI by the online application deadline. Registrations received after the deadline will be returned unprocessed. MAILED OR FAXED REGISTRATIONS ARE NOT ACCEPTED. Read the Candidate Handbook before completing, refer to reTEST Assured Program section, page 9 for details. Email the completed form to ampexamservices@psionline.com.

Once received, candidates will be notified via email informing them the registration has been approved with instructions on how to pay the $125 reTEST fee and schedule the exam.

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

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

2. I am a:

☐ reTEST Assured program candidate who must retest in one of the next three windows and submit a new completed application to PSI. Candidates can use the reTEST Assured program one-time after non-passing score. Do not submit the reTEST Assured registration form until you are ready to test.

☐ reTEST Assured program candidate who already submitted and has been approved for **Special ExaminationAccommodations**. I understand once eligible I will ONLY be able to schedule the exam by contacting PSI exam accommodations at 800-367-1565 ext. 6750.

3. Examination Fee: $125 fee
   a. Payment Information will be entered by you on your online account prior to scheduling the exam.

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. The audit letter from PSI will indicate the date the documentation must be received. You will be notified by PSI when the audit is approved and you are eligible to schedule the exam.

Attestation and Signature (Check each box to attest to your agreement to the statements 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.

Non-disclosure of Exam Content

☐ Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except HPCC. Per HPCC policy, sharing of exam content is cause for revocation of certification. I certify that I have read that all examination questions are the copyrighted property of HPCC and it is forbidden under federal copyright law to copy, reproduce, record, distribute, or display the examination questions by any means, in whole or in part. Doing so may subject me to severe civil and criminal penalties.

Ethics

☐ I understand the importance of ethical standards and agree to act in a manner congruent with the HPNA Code of Ethics for Nurses.

Attestation and Signature (Your signature in ink attests to your agreement to the above statements.)

Name (Please Print) Signature Date

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 an APRN in the United States, its territories or the equivalent in Canada.
☐ Nurse Practitioner ☐ Clinical Nurse Specialist
Mail a copy of your APRN license to: HPCC Certification Examination APRN License, PSI, 18000 W. 105th St., Olathe, KS 66061-7543 or email to ampexamservices@psionline.com.

☐ Licensure: State_____ APRN License Number _____ APRN License Expiration_____

☐ 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.

☐ Completion of an accredited graduate, postgraduate, or doctoral Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) educational program from a U.S. school or Canadian province NP or CNS educational programs approved by the Canadian Council of Registered Nurse Regulators (CCRNR).

☐ Completion of three separate comprehensive graduate-level courses in advanced pathophysiology, advanced health assessment, and advanced pharmacology.

Registered Nurse Examination

☐ I am currently licensed as a registered nurse in the United States, its territories or the equivalent in Canada.

☐ Licensure: State_____ RN License Number_____ RN License Expiration _____

☐ 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.

☐ Licensure: State_____ RN License Number_____ RN License Expiration _____

☐ 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.

☐ Licensure: State_____ LPN/LVN License Number_____ LPN/LVN License Expiration _____

☐ I have worked as a licensed practical/vocational nurse under the supervision of 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.

Nursing Assistant Examination

☐ I have worked as a nursing assistant under the supervision of 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.

Within the last five (5) years:

Yes	No	
☐	☐	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.

I understand that no refunds will be issued once payment is processed.

Name (Please Print) Signature Date

Nursing Practice Verification: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

Verifier's Name (Last) (First) Facility Name

Verifier's Phone Number Verifier's Email Address

You may not list yourself or a relative as your verifier.

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