



PRIMARY CARE PNP EXAM APPLICATION

Pediatric Nursing Certification Board, Inc.

800 South Frederick Avenue, Suite 204, Gaithersburg, MD 20877-4152
301-330-2921 or 1-888-641-2767 (Toll-free) FAX: 301-330-1504 www.pncb.org

APPLY ON-LINE CONVENIENT & FAST [WWW.PNCB.ORG](http://www.pncb.org)

Application must be completed and signed. All fees must be paid in full before application is processed. Take advantage of our convenient and fast online registration which includes the ability to view application and order history, update personal information, receive communication from PNCB staff and view recertification history. Register today at www.pncb.org.

- Pathway I (graduated within 24 months)
- Pathway II (graduated more than 24 months ago)

1. Last 4 digits of SSN _____ 2. Gender F M
(SSN is confidentially maintained and will not appear on certification documents.)

3. Name (*Print your legal name*) _____
(Clearly print your name as you wish it to appear on your certificate.)

4. Other Name _____

5. Address _____ Apt. # _____
(Please notify the PNCB of any change in address as soon as possible.)

City _____ State _____ Zip _____

6. Contact Information (*Include Area Code*)

Home (_____) _____

Work (_____) _____ EXT. _____

Pager (_____) _____

Cell Phone (_____) _____

Email _____ @ _____ ● _____
(We will only use email to communicate to you about your certification and to provide info and updates.)

7. Citizenship US Other _____ 8. Birth Country _____

9. Date of Birth _____

10. Years of RN Experience: _____ Years in Peds Nursing: _____

11. Current RN Practice & License Information

A. Hours per week in nursing (if applicable):
 More than 30 hours per week in nursing
 Less than 30 hours per week in nursing
 Not currently working in nursing

B. RN License Information (Required)

A. RN License # _____

B. Expiration Date _____

C. State _____

12. Employment

A. Employment Status (print digit code) _____
 Not employed in nursing (1)
 Currently practicing in pediatric nursing (2)
 Practicing in nursing, not pediatric (3)

B. Employment Settings (print digit code) _____
 Children's Hospital (1)
 Community Hospital (2)
 Other (3)

C. Employment Position (print digit code) _____
 Staff Nurse (1) Nurse Supervisor/Manager (2)
 Nurse Administrator (3) Nurse Consultant (4)
 Nurse Researcher (5) Nurse Educator (6)
 Clinical Nurse Specialist (7) Nurse Practitioner (8)
 Other (9) Not Employed (10)



The Pediatric Nursing Certification Board, Inc.

800 South Frederick Avenue, Suite 204, Gaithersburg, MD 20877-4152 (888) 641-2767 or (301) 330-2921
Take advantage of on-line enrollment and SAVE. Go to www.pncb.org for fast and efficient, secure and safe on-line enrollment.

Credit Card Payment Form

Complete & sign for credit card payments:

Print Name: _____

Last 4 digits of SSN: xxx-xx-_____

I authorize the PNCB to charge my VISA, MasterCard, American Express or Discover (please circle):

\$ _____ (_____) _____
Amount Account Number (+3 digit security code) Expiration Date
(last three numbers located on the back of credit card)

If this is a personal card complete this section:

Cardholder Mailing Address:

Phone Number: _____

★ Printed Name of Cardholder:

★ Cardholder Signature:

If you are using a business credit card, complete this section:

Business Name and Address associated with the above credit card:

Phone Number: _____

★ Printed Name as it appears on card:

★ Cardholder Signature:

DOCUMENTATION OF PNP EDUCATION FORM

PEDIATRIC NURSING CERTIFICATION BOARD, INC.
800 S. Frederick Avenue, Suite 204, Gaithersburg, MD 20877-4152
1-888-641-2767 - www.pncb.org

The PNP Exam applicant must be a graduate of a program granting a PNP Master's degree in nursing or of a Post Master's PNP program included on the PNCB's list of recognized programs preparing pediatric nurse practitioners. Inclusion on the PNCB listing indicates that a program has met the standards for PNP education, as set forth by the American Association of Colleges of Nursing, the Commission on Collegiate Nursing Education (CCNE), the National Organization of Nurse Practitioner Faculties (NONPF), the Association of Faculties of Pediatric Nurse Practitioners (AFPNP) Programs and the PNCB.

All information below must be provided. Blank items will invalidate this form. This form must be completed and signed by both the Applicant and Program Director or appropriate designee in order for form to be valid. We are unable to accept a digital/electronic or stamped signature.

PNP EXAM APPLICANT MUST COMPLETE #1-11. PROGRAM DIRECTOR MUST COMPLETE #12.

1. Please select the appropriate PNP Exam:
 Primary Care PNP Exam
 Acute Care PNP Exam

2. Please select the appropriate student and eligibility Pathway that represents your graduate PNP status:
 Master's student
 Pathway I (graduated w/in 24 months From Master's PNP Program)
 Pathway II (more than 24 months since completion of Master's PNP Program)
 Post Master's student
 Pathway I (graduated w/in 24 months From Post Master's PNP Program)
 Pathway II (more than 24 months since completion of Post Master's PNP Program)

3. **Applicant printed name:** _____
Applicant signature: _____

4. Date: _____

5. Applicant last 4 digits of SSN: _____

6. Name of School:

7. Address of School:

8. Program Number/Code: _____ (3 digit # for PC Programs and 4 digit # for AC Programs)
Go to www.pncb.org and "Recognized Programs" to find Program Number/Code assigned to your graduate PNP program.

9. Date PNP option of above named program was completed: _____

10. Date MSN degree awarded: _____

11. Date Post Master's certificate awarded (if applicable): _____

12. PROGRAM DIRECTOR MUST VERIFY APPLICANT INFORMATION ABOVE, SIGN BELOW, AND MAIL TO PNCB.

I verify that the above named applicant has completed the appropriate PNP curriculum as approved by the PNCB. This program meets the terms and dates for program recognition as determined by the PNCB.

Signature of Program Director: _____

Printed Name of Program Director: _____

Date: _____

This Documentation of PNP Education Form must be submitted directly to the PNCB from the educational institution in a formal university mailer.

Mail to: PNCB, 800 S. Frederick Avenue, Suite 204, Gaithersburg, MD 20877-4152.



The Pediatric Nursing Certification Board, Inc.
800 S. Frederick Avenue, Suite 204

PATHWAY II

Gaithersburg, MD 20877-4152

Skills
Verification Form

TOLL FREE (888-641-2767) FAX (301-330-1504)

PATHWAY II (graduated more than 24 months ago)—PNP SKILLS VERIFICATION FORM

To the applicant: Please print or type your name in the space provided below and forward this form to a physician supervisor or pediatric nurse practitioner who has knowledge of your clinical practice skills and can verify your current practice competency as a PNP.

PNP Name _____

SSN _____

Dear Colleague:

The above Pediatric Nurse Practitioner has given your name to verify that he/she has functioned as a pediatric nurse practitioner, regularly and competently performing the functions indicated. Please complete and sign this form and return to the above named PNP.

I, the undersigned, have observed _____ perform in the role of a pediatric nurse practitioner. I attest that the above-named individual performs pediatric examinations and develops and carries out appropriate care according to standards generally accepted in primary care. I have served with this candidate in clinical practice for _____ (months/years).

Yes	No	
		1. Secures a child's (0 to young adult) health and development history from client or his/her parent and records findings in a systematic, accurate and succinct form.
		2. Critically evaluates the health history developing strategies for collection of objective data.
		3. Performs an age appropriate pediatric physical assessment on children using appropriate techniques of physical examination (inspection, auscultation, palpation and percussion) along with appropriate use of instrumentation (otoscope, ophthalmoscope, and stethoscope) and other assessment technologies as needed.
		4. Discriminates between normal and abnormal findings on screening physical assessment and laboratory data.
		5. Constructs an appropriate plan of care, critically assessing history, physical assessment findings and laboratory data as indicated.
		6. Selects and utilizes appropriate developmental screening tests to perform an accurate and appropriate developmental evaluation.
		7. Identifies and manages acute and chronic childhood conditions.
		8. Provides anticipatory guidance to children & parents concerning problems of child rearing, such as: feeding, developmental crises, common illnesses and accidents.
		9. Identifies community health resources and guides parents in their use.
		10. Appropriately and accurately communicates health assessments and plan of care, to include diagnostic judgments and therapeutic interventions, to members of the health team. Provides for appropriate referral.

Signature _____

Date _____

Print Name _____

Position/Title _____

Address _____

City _____

State _____

Zip Code _____

Telephone _____

Email _____