

# SKIN AND WOUND MANAGEMENT COURSE REGISTRATION



**WOUND CARE**  
EDUCATION INSTITUTE

Submit completed application  
and fees to:

**MAIL**

Indiana Health Care Association  
Attn: Katie Eller  
One North Capitol Ste 100  
Indianapolis, IN 46204

**FAX**  
1-317-638-3749

Make checks or money orders  
payable to:

Indiana Health Care Association

FOR WCEI Cancellation Policy  
visit us on the web at  
[www.wcei.net](http://www.wcei.net) or  
call us at 877-462-9234

Name \_\_\_\_\_

Home Address Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Current Employer or Facility \_\_\_\_\_

Phone \_\_\_\_\_ E-Mail (Required for confirmation) \_\_\_\_\_

Professional License Number (Must have for CEU's) \_\_\_\_\_ Type of License \_\_\_\_\_ State Issued \_\_\_\_\_

Emergency Contact during week of course (name and phone #): \_\_\_\_\_

ADA statement- Please Contact me, I have special needs

**Select WCEI COURSE Location**

October 29 – November 2, 2012  
Golden Living Training Center  
8460 Bearing Drive  
Indianapolis, IN 46268

**Select Registration Type**

Any changes or transfers to applications once they have been processed will result in a \$200.00 change fee.  
Registration fees include Books, Materials, clinical support.

✓	Registration (See above)	Cost per Each	How many	Total
	IHCA Member Price	\$2297.00		
	IHCA Non-Member Price	\$2597.00		





**NATIONAL ALLIANCE OF WOUND CARE®**  
**WCC® EXAMINATION APPLICATION page 2**  
 (You may make copies of this page as needed to document required experience.)

**12. WORK EXPERIENCE VERIFICATION**

**a. Complete the following sections to document required wound care related work experience.**

Candidate's Name (Please print) \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employment Dates From: \_\_\_/\_\_\_/\_\_\_ to: \_\_\_/\_\_\_/\_\_\_  Full Time  Part Time

Supervisor Name: \_\_\_\_\_ Supervisor Phone Number: \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employment Dates From: \_\_\_/\_\_\_/\_\_\_ to: \_\_\_/\_\_\_/\_\_\_  Full Time  Part Time

Supervisor Name: \_\_\_\_\_ Supervisor Phone Number: \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employment Dates From: \_\_\_/\_\_\_/\_\_\_ to: \_\_\_/\_\_\_/\_\_\_  Full Time  Part Time

Supervisor Name: \_\_\_\_\_ Supervisor Phone Number: \_\_\_\_\_

**b. This section to be completed by current supervisor.**

The individual named above has applied for WCC® certification examination. Eligibility criteria require candidates to document their clinical wound care experience. Please help this candidate to document relevant experience by completing the following statement:

- I verify that the candidate named above was actively involved in the treatment of wound care patients, or in management, education or research directly related to wound care, while actively licensed, for a MINIMUM of 2 years full-time or 4 years part-time within the past 5 years.

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Supervisor Name

\_\_\_\_\_  
Supervisor Phone Number

**NATIONAL ALLIANCE OF WOUND CARE®  
WCC® EXAMINATION APPLICATION Page 3**



**13. AGREEMENT AUTHORIZATION and CERTIFICATION INFORMATION RELEASE**

I hereby affirm that I have been a \_\_\_\_\_ actively and directly involved in the delivery of wound care or in  
(License Type)  
Management, Education or Research directly related to wound care for a:

- MINIMUM of two years full-time or four years part-time within the past five years.  
or
- MINIMUM of four years full-time within the past five years.

I further affirm that I am currently licensed to practice as a \_\_\_\_\_ in the state of \_\_\_\_\_.  
(License Type)

I further affirm that no licensing authority has current disciplinary action pending against my license to practice in the aforementioned or any other state, and that my license to practice is not currently suspended, restricted or revoked by any state or jurisdiction.

I authorize the National Alliance of Wound Care® to make whatever inquires and investigations that is deems necessary to verify my credentials and professional standing. I further allow the National Alliance of Wound Care® to use information from my application and subsequent examination for the purpose of statistical analysis, provided my personal identification with that information has been deleted.

I hereby understand the National Alliance of Wound Care® will publish and my name, professional license type, city, state, past and present certification status under the NAWC® WCC® Certification Directory, in print and electronic versions of a worldwide directory of NAWC® WCC® Certified Practitioners. I release the NAWC®, its subsidiaries and affiliates and their employees, successors and assigns from any claims of damages for libel, slander, invasion of rights of privacy or publicity, and any other claim based on the publication or release of any Certification Information as specified in this Certification Information Release.

As the applicant, I declare that the foregoing statements are true. I understand false information may be cause for denial or loss of the credential.

\_\_\_\_\_  
**Applicant signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

**Please send completed registration forms to:**

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Indianapolis, IN 46204