WOUND CARE EDUCATION INSTITUTE

DIABETIC WOUND MANAGEMENT COURSE

ONLINE COURSE REGISTRATION

Submit completed application and fees to:

MAIL: Indiana Health Care Association | Attn: Katie Niehoff | One N Capitol - Ste 100 | Indianapolis IN 46204

FAX: 317-638-3749

APPLICANT

Name (First, Middle, Last)

Street Address **City** **State** **Zip Code**

Phone Number **Email** (Required for Confirmation)

Current Employer or Facility (Name and Address)

ADA Statement

☐ Please contact me, I have special needs.

PLEASE SELECT YOUR DIABETIC WOUND MANAGEMENT COURSE

ONLINE Course Selection

◯ $2,597 Standard Rate

◯ $1,797 WCEI Alumni Rate

Coupon Code *Insert Coupon Code Here* **TOTAL DUE**

CREDIT CARD AUTHORIZATION

I authorize IHCA to charge $ to my ◯ Visa ◯ MasterCard ◯ AMEX ◯ Discover

Card Number **Expiration Date** **Security Code**

Cardholder Name on Credit Card Statement (First, Middle, Last or COMPANY NAME)

☐ *Information is same as above*

Cardholder Telephone Number **Cardholder Billing Address** (Street, City, State, Zip Code)

Authorized Cardholder Signature **Date**

Digital Signature Acknowledges Agreement and Verification of Information Provided

NATIONAL ALLIANCE OF WOUND CARE AND OSTOMY™
DIABETIC WOUND CERTIFIED (DWC™)
ONLINE EXAMINATION APPLICATION

Missing or incomplete Information will delay Application processing

1. PRINT NAME: (As listed on your Professional License)

LAST: FIRST: MIDDLE:

2. MAILING ADDRESS:

STREET:

3. DATE OF BIRTH:

MM/DD/YYYY:

CITY: STATE / PROVINCE: COUNTRY: ZIP / POSTAL CODE:

DAYTIME TELEPHONE #: EVENING TELEPHONE #: E-MAIL: **REQUIRED FOR CONFIRMATION**

4. EXAMINATION:

Computerized Testing Center

With the Computerized Testing Center option, you will receive a confirmation notice that includes a toll free number to contact PSI Computer Testing, Inc. for scheduling the examination at a testing center.
A list of available testing centers may be viewed at www.psiexams.com

5. ADA ACCOMMODATION:

☐ YES

Special arrangements will be necessary for me to complete the examination.
(If yes, contact NAWCO® for instructions.)

6. PROFESSIONAL LICENSES: (Check all that apply)

☐ LPN / LVN ☐ RN ☐ NP / APN ☐ OT

☐ PTA ☐ PT ☐ PA ☐ MD / DO / DPM

License Number(s): _____

Issuing State: _____ **ORIGINAL** Issue Date: _____

Expiration Date: (mm/dd/yyyy): _____

7. EDUCATION:

☐ Diploma ☐ MSN
☐ Associate ☐ PhD
☐ BS ☐ MD / DO/ DPM
☐ BSN ☐ Other: _____
☐ BA

Field of Study: _____

8. WOUND CARE CERTIFICATIONS: (Check all that apply – If you are currently certified in Wound Care #11 Work Experience Verification is not necessary)

☐ WCC Certification #: _____ Date of Initial Certification: _____

☐ CWS Certification #: _____ Date of Initial Certification: _____

☐ CWCN Certification #: _____ Date of Initial Certification: _____

☐ CWON Certification #: _____ Date of Initial Certification: _____

☐ CWOCN Certification #: _____ Date of Initial Certification: _____

9. PRIMARY PLACE OF EMPLOYMENT:

☐ Hospital ☐ Outpatient ☐ Long Term Care

☐ Education ☐ Home Care ☐ Administration

☐ Sales ☐ Independent Consultant

10. EXPERIENCE / PRACTICE IN WOUND CARE SINCE WOUND CARE CERTIFICATION:

☐ Less than One Year
☐ One to Two Years
☐ Two to Five Years
☐ More than Five but fewer than Ten
☐ Ten or more Years

Office Use:

ELG: Y N CERT ISSUE: VER DATE:
ACT: Y N CERT EXP: INITIALS:
DISP: Y N ID:

Sponsored by: Indiana Health Care Association

11. WORK EXPERIENCE VERIFICATION – To Be Completed ONLY if you are NOT currently Wound Care Certified

Complete the following section(s) to document required **2 YEARS** full-time or 4 YEARS part-time within the past 5 years of active involvement in the care of diabetic patients, or in management, education or research directly related to diabetes.

Name: (Please Print) _____

Employer Name: _____

Employer Address: (Street, City, State & Zip) _____

☐ Current Employer

Employment Dates: From _____ - _____ - _____ to _____ - _____ - _____ ☐ Full Time ☐ Part Time

You Must Specify Full or Part Time

Supervisor Name: _____ Supervisor Telephone #: _____

Employer Name: _____

Employer Address: (Street, City, State & Zip) _____

☐ Current Employer

Employment Dates: From _____ - _____ - _____ to _____ - _____ - _____ ☐ Full Time ☐ Part Time

You Must Specify Full or Part Time

Supervisor Name: _____ Supervisor Telephone #: _____

12. AGREEMENT AUTHORIZATION and CERTIFICATION INFORMATION RELEASE

a. I hereby affirm that I have been a(n) License Type actively and directly involved in the care of diabetic patients, or in Management, Education or Research directly related to diabetes while actively licensed for at least two (2) years full-time or four (4) years part-time within the past five (5) years.
-OR-
Currently hold an accredited certification in wound care.

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

c. 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 Wound Care Education Institute and the National Alliance of Wound Care and Ostomy™ to make whatever inquiries and investigations deemed necessary to verify my credentials and professional standing. I further allow the National Alliance of Wound Care and Ostomy™ 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 and Ostomy™ will publish my name, professional license type, city, state, past and present certification status under the NAWCO® DWC™ Certification Directory, in print and electronic versions of a worldwide directory of NAWCO® DWC™ Certified Practitioners. I release the NAWCO®, 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's Digital Signature Acknowledges Agreement and Verification of the Information Provided.

_____ _____

Applicant Signature Date

_____

Printed Name