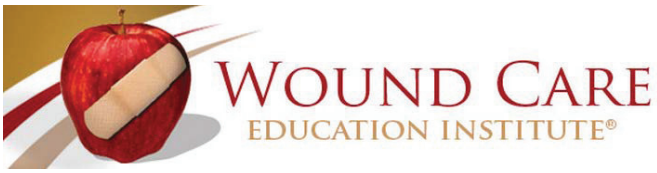

WOUND CARE EDUCATION INSTITUTE
Submit completed application & fees to:
Mail: Indiana Health Care Association **Fax:** 317-638-3749
Attn: Emily Berger
One N Capitol - Ste 100
Indianapolis IN 46204

Skin and Wound Management Onsite Course Registration

APPLICANT: (Please print all information legibly)

Name (First, Middle, Last)

Address (Street, City, State & Zip Code)

Phone Number **E-Mail (Required for Confirmation)**

Current Employer or Facility (Name & Address)

❑ ADA Statement – Please Contact Me, I have special needs

SELECT WCEI® COURSE LOCATION:
Indicate WCEI® Course Location Choice
Available Dates & Locations listed on www.wcei.net Web Site

Indianapolis IN
City / State

Week of October 16-20, 2017

How did you find out about the WCEI® course?
❑ Post Card / Direct Mail
❑ Nursing Spectrum / Nurse.com
❑ Advance Magazine LTC
❑ Nursing Association Nurse 2013
❑ Google Search
❑ Yahoo Search
❑ Other Internet Search
❑ Web Site (Please Specify)

❑ Referral (Please Provide Full Name)
IHCA
❑ Other (Please Specify)

SELECT REGISTRATION TYPE:
ALL Early Bird Fees are Required **PAID IN FULL** 45 days prior to course start date

Registration Type (See Above)	Cost per Person	Total
Individual Registration - IHCA Member	$2497.00	
Individual Registration - Non-Member	$2997.00	
Coupon Code: IHCA17		
Make Checks or Money Orders Payable to Wound Care Education Institute	**TOTAL DUE**	

CREDIT CARD AUTHORIZATION: (Please print all information legibly)

Attendee Name (First, Middle, Last)

Attendee Address (Street, City, State & Zip Code)

I authorize Wound Care Education Institute to charge $_____ to my: ❑ VISA ❑ MasterCard ❑ AMEX ❑ Discover

Card Number **Expiration Date** **Security Code** *(3-4 digits on signature strip)*

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

Cardholder Billing Address (Street, City, State & Zip Code) ❑ **SAME AS ABOVE**

Authorized Cardholder Signature ***Digital Signature Acknowledges Agreement & Verification of Information Provided*** **Date**

For WCEI Cancellation Policy visit us on the web at www.wcei.net or call us at 877-462-9234

IHCA WCC Exam Application

Fax Completed form to: 1-877-649-6021 -OR- Email to: admissions@wcei.net

Questions: Call Wound Care Education Institute: 877-462-9234

National Alliance of Wound Care and Ostomy™

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. 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): _____

5. EDUCATION:

☐ Diploma ☐ MSN

☐ Associate ☐ PhD

☐ BS ☐ MD / DO/ DPM

☐ BSN ☐ Other:

☐ BA _____

Field of Study: _____

6. WOUND CARE CERTIFICATIONS: (Check all that apply)

☐ CWS / CWCA Certification #: _____

☐ CWCN Certification #: _____

☐ CWON Certification #: _____

☐ CWOCN Certification #: _____

7. LICENSED EXPERIENCE / PRACTICE IN WOUND CARE:

MINIMUM of 2 YEARS

Must be completed by Exam Date

☐ Two to Five Years

☐ More than Five but fewer than Ten

☐ Ten or more Years

8. PRIMARY PLACE OF EMPLOYMENT:

☐ Hospital ☐ Outpatient ☐ Long Term Care

☐ Education ☐ Home Care ☐ Administration

☐ Sales ☐ Independent Consultant

9. ADA ACCOMMODATION:

☐ YES

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

10. EXAMINATION TYPE:

☒ On Site at WCEI® Skin and Wound Management Course

Course Location: Indianapolis IN

Course Dates: October 16-20, 2017

(An acceptance letter and NAWCO® Candidate Handbook will be emailed to you with your WCEI® course confirmation. If you elect to change your testing site after the confirmation is sent, you will be charged an additional $75.00 administrative fee.)

Office Use Only: **Code: IHCA17**

ELG: Y N

ACT: Y N

DISP: Y N

VER DT: _____ BY: _____

ID: _____

NATIONAL ALLIANCE OF WOUND CARE AND OSTOMY™
NAWCO® EXAMINATION ONSITE APPLICATION page 2
(You may make copies of this page as needed to document required experience)

National Alliance of Wound Care and Ostomy™

11. WORK EXPERIENCE VERIFICATION
Complete the following sections to document required wound care related work experience.

Candidate's 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

I hereby affirm that I have been a(n) License Type _____ actively and directly involved in the delivery of wound care or in 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.

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

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 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® WCC® Certification Directory, in print and electronic versions of a worldwide directory of NAWCO® WCC® 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