



Application for Recertification by Contact Hours

Contact Information (Please print):

Name: _____

Address: _____

City, State, Zip: _____

Daytime Phone: _____ Fax: _____ Email: _____

Demographic Information (please indicate):

Highest educational level:

Diploma Nurse Associates Degree/Nursing Bachelor's Degree/Nursing

Master's Degree Doctoral Degree Other _____

Primary Place of Employment: Hospital Clinic Private Office Other

Hours Worked Per Week: Part-time (less than 20) Part-time (more than 20) Full Time

Years of Gastroenterology Experience: 2-5 6-10 11-15 16-20 21-25 26+

The following questions are optional and are asked to ensure that ABCGN is complying with Federal equal opportunity guidelines:

Please indicate your ethnicity: African American American Indian Asian Caucasian

Hispanic Other _____

Please indicate your age range: Under 25 25-29 30-39 40-49 50-59 60+

Please indicate your gender: Female Male

Statement of authenticity (note, unsigned applications will not be processed): By signing below I affirm the information contained in this application is true.

Signature: _____ Date: _____



Verification of Professional Qualifications Form

This form must be completed and submitted with the Application Form***

Verification of professional qualifications is required of all candidates submitting an application. This must be completed by two responsible practitioners in the gastroenterology/endoscopy specialty. These may be nursing colleagues, physicians or administrators or representatives of the human relations department of the candidate's place of employment.

Contact Information 1 (Please print):

Name: _____

Title: _____ Organization: _____

Address: _____

City, State, Zip: _____

I certify that to the best of my knowledge the listed work experience is correct and complete.

Signature: _____ Date: _____

Contact Information 2 (Please print):

Name: _____

Title: _____ Organization: _____

Address: _____

City, State, Zip: _____

I certify that to the best of my knowledge the listed work experience is correct and complete.

Signature: _____ Date: _____

Test Site Code (if applicable): _____ City, State: _____

License Number: _____ Expiration Date: _____

*Also attach a photocopy of license)

To the best of my knowledge all information contained in this application is true:

Signature: _____ Date: _____

Name (please print): _____

Daytime Phone: _____ Email: _____

Present Employer: _____

City, State, Zip: _____

Years/Month you have been with this organization: _____

Previous Employment in Gastroenterology/Endoscopy:

Employer: _____

City, State, Zip: _____

Years/Months you have been with this organization: _____

Employer: _____

City, State, Zip: _____

Years/Months you have been with this organization: _____

Employer: _____

City, State, Zip: _____

Years/Months you have been with this organization: _____

Employer: _____

City, State, Zip: _____

Years/Months you have been with this organization: _____

Mail completed packet by certified mail to: ABCGN, 401 N. Michigan Avenue, Chicago, IL 60611-4267

ABCGN Code of Conduct

Protecting the public through professional standards

The American Board of Certification for Gastroenterology Nurses (ABCGN) provides certification for the gastroenterology and gastroenterology/endoscopy nurses. The purpose of the ABCGN voluntary certification process is to assure consumers, the public, and employers that individuals certified by ABCGN are capable and competent, have successfully passed a certification exam that is a researched, tested and validated, and have been judged to be qualified. The ABCGN is dedicated to the principle that professionals in the field of gastroenterology and gastroenterology/endoscopy nursing must conform their behavior to the highest standards of ethical practice. To that end, the ABCGN has adopted this *Certified Professional Code of Conduct*, to be applied to all professionals, certified or seeking certification.

Rules of Conduct

The following Rules of Conduct, adopted by the ABCGN, set forth the minimum standards of conduct which all certified professionals or those seeking certification are expected to honor. Failure to comply with an obligation or prohibition set forth in the Rules may result in disciplinary action by the ABCGN.

As a certified nurse or nurse seeking certification, I:

- shall meet and comply with all terms, conditions, or limitations of any professional certification or license which I hold.
- shall not perform services outside of my area of training, expertise, competence, or scope of practice.
- shall not fail to obtain an appropriate consultation or make an appropriate referral when the consumer's problem is beyond my area of training, expertise, competence, or scope of practice.
- shall not in any way participate in discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, socio-economic status, political belief, physical disabilities or mental impairments.
- shall serve as a role model for certified gastroenterology/endoscopy nursing professionals. This includes both at the professional level of performing my job function to the highest standards and meeting all state licensure, regulatory, hospital, and SGNA practice standards; as well as at the personal level through peer support and mentoring.
- shall report any failure of my certified peers to meet the ethical standards and certification requirements to my employer and ABCGN.
- shall not use misrepresentation in the application for certification/recertification; or assist another in the preparation of an application through misrepresentation. The term "misrepresentation" includes but is not limited to the misrepresentation of professional qualifications, certifications, accreditation, affiliations, employment experience, educational experience, the plagiarism of application and recertification materials, or the falsification of references.
- shall report any violation of the Code of Conduct.
- shall not file a complaint or provide information to the ABCGN which I know, or should have known, to be false or misleading.

By signing this form I agree to adhere to the ABCGN Code of Conduct and acknowledge that violation of the ABCGN Code of Conduct will result in a suspension or revocation of my certification credentials.

_____ (Name Printed)

(Name Signature)

Date



ABCGN Recertification Verification Form

Name: _____

Date of initial certification: _____

Date of last certification: _____

Contact Hours Recertification Requirements

The candidate seeking recertification status from the American Board of Certification for Gastroenterology Nurses must submit documentation of 100 Contact Hours within the five year period prior to the certification expiration date in order to maintain his/her certification. At least eighty (80) contact hours must be GI-specific and at least 40 of the GI-specific contact hours must have been earned through attendance at approved nursing seminars and workshops (Category 1).

Directions

1. Print or type all information legibly.
2. Submit the original copy of this application, retaining a photocopy for your records.
3. Send the application and all supporting documentation via "certified mail, return receipt requested."

Photocopy the forms as necessary.

I affirm that the following information is true:

Signature: _____ Date: _____

***Your recertification will not be processed without a signed form.**

Category 1:

Attendance at Nursing CE Approved Seminars / Workshops (Minimum: 40 GI-Specific contact hours)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

Category 2:

Providing Presentations (Minimum: None - Maximum: 50)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 3:

Professional Publications (Minimum: None - Maximum: 50)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 4:

Academic Credit Course Work (Minimum: None - Maximum: 20)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 5:

Continuing Education Independent Home Study (Minimum: None - Maximum: 60)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 6:

ABCGN Item Writers Workshop (Minimum: None - Maximum: 20)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 7:

Continuing Medical Education (CME's) (Minimum: None - Maximum: 30)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 8:

Nursing Research Projects (Minimum: None - Maximum: 40)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Category 9:

Poster Presentation (Minimum: None - Maximum: 10)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

**Verification Form Poster Presentations
ABCGN**

Name: _____

Check One: GI Specific Non GI Specific

Contact hours claimed for this poster presentation: _____

Please complete a separate form for each poster presentation.

Title of poster presentation: _____

Where presented: _____

When presented: _____

Abstract included Photo of poster included

Signature: _____

Signature verifies I was involved in developing and presenting this poster.

Documentation required if audited

Category 10:

Preceptorship (Minimum: None – Maximum: 5)

Five (5) Contact Hours will be awarded to the CGRN for **80** hours of precepting an RN/LPN/GI Tech within a GI work setting. A GI work setting is defined as working in a Gastroenterologist Office or GI Unit (Hospital or Ambulatory Surgery/Endoscopy Center). The maximum amount awarded is **5** GI Specific contact hours, in a **5** year period. No contact hours will be awarded for Non-GI work settings.

I VERIFY THAT (NAME)

SERVED AS A PRECEPTOR FOR STAFF MEMBER (RN, LPN, TECH)

FROM: (DATE TO DATE) FOR A **MINIMUM** OF 80 HOURS

SIGNATURE OF NURSE MANAGER/DIRECTOR

NAME/ADDRESS OF INSTITUTION

CONTACT NUMBER

DATE

SIGNATURE OF CGRN

CONTACT NUMBER

DATE

My signature attests to the fact that the information provided is accurate.

Category 11:

Involvement in ABCGN/SGNA/or SIGNEA organizations or publications (Minimum: None – Maximum: 15)

Three (3) contact hours per year will be awarded for involvement in these GI focused professional organizations as an officer, committee/task force member at the regional or national level or as an appointed publication editor/reviewer.

Minimum GI specific hours granted will be 3, maximum 15. Non-GI specific contact hours will not be awarded. (Item Review Committee and Item Writing Panel use Category 12.)

VERIFICATION OF INVOLVEMENT IN A PROFESSIONAL ORGANIZATION:

I VERIFY THAT (NAME)

HAS SERVED AS AN OFFICER
(NAME OF OFFICE HELD/ORGANIZATION)

DATES OF SERVICE

HAS SERVED AS A COMMITTEE/TASK FORCE MEMBER
(NAME OF COMMITTEE/TASK FORCE)

DATES OF SERVICE

NAME OF GI FOCUSED PROFESSIONAL ORGANIZATION

VERIFICATION SIGNATURE (to be signed by officer of organization)

TITLE

ORGANIZATION

TELEPHONE

DATE

CGRN SIGNATURE

DATE

My signature attests to the fact that the information provided is accurate.

Category 12:

ABCGN Test Development (Minimum: None – Maximum: 48)

Up to twelve (12) GI Specific contact hours per year will be awarded for participation on the Item Review Committee and/or Item Writers Panel. You can submit up to a maximum of 48. You will be awarded a certificate to present with recertification.

The attached certificate verifies that:

NAME

HAS SERVED AS A MEMBER OR CHAIR OF THE ABCGN ITEM REVIEW COMMITTEE

HAS SERVED AS A MEMBER OF THE ABCGN ITEM WRITERS PANEL

DATES OF SERVICE

CGRN SIGNATURE

DATE

My signature attests to the fact that the information provided is accurate.



Payment Form

Candidate Name: _____

Mailing Address: _____

Daytime Phone: _____ Email: _____

Applying For (check one): _____ Certification _____ Recertification

SGNA Member (check one): _____ Yes _____ No

Fees	SGNA Member	Non-SGNA Member
Examination Fee		
Paper and Pencil Exam (spring only)	\$300	\$385
Computer-based Exam	\$400	\$485
TOTAL AMOUNT		
Recertification Fee (if applying through Contact Hours)	\$300	\$385
TOTAL AMOUNT		
Form of Payment (Circle)		
Check	Credit Card (VISA, MC, AMEX)	
Cardholder's Name:	Card Number:	Expiration Date:
Signature:		