

ABCGN Certification Examination Application

3 Easy Steps to Apply

1. Visit our Web site, www.abcgcn.org, and print off the Certification Exam Handbook. Please review before sending in your application.
2. Complete the Certification Application and attach a copy of your nursing license, prominently marked "Copy" and your membership number if submitting SGNA member discounted fees.
3. Send the application and all supporting documentation via CERTIFIED MAIL, return receipt requested to insure your application has been received.



Eligibility Requirements

ABCGN certification is open to Registered Nurses in GI. At the time of application, a candidate must have been employed in a clinical, supervisory, administrative, teaching/education and/or research capacity in the field of gastroenterology in an institutional or private practice setting for a minimum of two years full-time, or its part-time equivalent of 4000 hours, within the past five years. Work experience must be at the level the candidate is certifying for. Verification of licensure and work experience is required.

Applying for: Initial Certification Recertification

Test Site 3-Digit Code: _____

City: _____

Contact Information

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DAYTIME PHONE NUMBER _____ NIGHTTIME PHONE NUMBER _____

FAX NUMBER _____

E-MAIL ADDRESS _____

Verification of Professional Qualifications

Verification of professional qualification is required for all candidates.

This must be completed by two responsible practitioners in the gastroenterology/endoscopy specialty.

1. NAME _____

TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

ORGANIZATION _____

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

SIGNATURE _____

DATE _____

Demographic Information

1. Education Level

- Diploma in Nursing
- Associate's Degree/Nursing
- Bachelor's Degree/Nursing
- Master's Degree
- Doctoral Degree
- Other _____

2. Place of Employment

- Hospital
- Clinic
- Private Office
- Ambulatory Center

3. Hours Worked Per Week:

- Part-Time 20 hours or less
- Part-Time more than 20 hours
- Full-Time

4. Years of Gastroenterology Experience

- 2-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26 or more years

5. Have you participated in a certification review course?

- Yes No

If yes, when and where?

6. Is this the first time you have taken the Certification Exam?

- Yes No

7. The following will be used for demographic purposes only. Your response is optional but appreciated.

Gender:

- Male Female

Ethnicity:

- Asian
- African American
- Caucasian
- Hispanic
- Native American
- Other _____

Age Range:

- Under 25
- 25-29
- 30-39
- 40-49
- 50-59
- 60 and above

2. NAME _____

TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

ORGANIZATION _____

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

SIGNATURE _____

DATE _____

(Continued on back)

ABCGN Certification Examination Application *(Continued)*

Work History

Present Employer

ORGANIZATION _____

CITY _____ STATE _____ ZIP: _____

YEAR/MONTHS WORKED _____

Previous Employment

ORGANIZATION _____

CITY _____ STATE _____ ZIP _____

YEAR/MONTHS WORKED _____

ORGANIZATION _____

CITY _____ STATE _____ ZIP _____

YEAR/MONTHS WORKED _____

ORGANIZATION _____

CITY _____ STATE _____ ZIP _____

YEAR/MONTHS WORKED _____

I certify that the information contained in this application is true:

SIGNATURE _____ DATE _____

Payment Information

(Fees subject to change)

Examination Fee SGNA Member. \$300

Examination Fee Non-SGNA Member. \$385

Late Registration deadline application will be assessed a \$50 late fee.

ABCGN application fees are non-cancelable and non-transferable. No refunds will be given.

Please refer to the Certification Handbook for the official Refund and Rollover policies.

Method of Payment

SGNA Member: Yes No

If yes, SGNA Membership ID Number: _____

Applicants Name _____

Check made payable to ABCGN enclosed for (amount): _____

Charge to credit card {check one}:

Visa MasterCard American Express

NAME AS IT APPEARS ON THE CARD _____

CARD # _____

EXPIRATION DATE _____

SIGNATURE _____



Please mail your completed application and payment to:

ABCGN Certification Exam
1967 Paysphere Circle
Chicago, IL 60674

Phone: 800-245-7462 option 3
Fax: 312-673-6723
Email: info@abcdn.org
Web: www.abcdn.org