CLINICAL NUTRITION CERTIFICATION BOARD

CERTIFIED CLINICAL NUTRIONIST (CCN)

EXAMINATION APPLICATION

The Clinical Nutrition Certification Board does not discriminate against any individual on the basis of religion, sex, ethnic background or physical disability.

All Completed Forms are Mailed to:

CNCB Credentials Office
400 Chisholm Place, Suite 303
Plano, TX 75075
(972) 250-2829 TEL * (972) 250-0233 FAX

CERTIFICATION WILL NOT BE AWARDED TO ANY PERSON WHO IS UNDER INVESTIGATION IN ANY JURISDICTION FOR AN OFFENSE WHICH WOULD CONSTITUTE A VIOLATION OF THE CODE OF PROFESSIONAL RESPONSIBILITY FOR CLINICAL NUTRITIONISTS UNTIL SUCH TIME AS THAT INVESTIGATION IS DISMISSED OR OTHERWISE TERMINATED.

APPLICATION

BEFORE COMPLETING THIS APPLICATION, YOU MUST READ THE CODE OF PROFESSIONAL RESPONSIBILTY
(Professional Practice Guidelines & Disciplinary Procedures).

I hereby certify that I have carefully and thoughtfully read The Code of Professional Ethics and Responsibility and agree to abide by and be found by its provisions.

_____
Signature of Applicant

NAME: _____ _____
LAST **FIRST --** **MI** **MAIDEN**

SOCIAL SECURITY NUMBER ----------

DATE OF BIRTH: _____ / _____ / _____

MAILING ADDRESS: _____
_____

HOME PHONE: ( ) _____ **WORK PHONE: ( )** _____

FAX: ( ) _____ **MOBILE: ( )** _____

MALE: _____ **FEMALE:** _____ **EMAIL** _____

DESIRED TEST DATE: _____/ _____/_____ **TEST CENTER:** _____

1. Are you practicing nutrition? _____ Yes _____ No
2. Full Time? _____ Yes _____ No
3. Part Time? _____ Yes _____ No
4. Number of years practicing:_____
5. Have you previously taken the CCN Certification Exam? _____ Yes _____ No
6. Have you ever been convicted of a felony or misdemeanor (other than a minor traffic violation)?
   _____ Yes _____ No If Yes, please explain.
   _____
7. Have you ever been found by any court, administrative or disciplinary proceeding to have committed negligence, malpractice, recklessness, willful or intentional conduct resulting in injury to another?
   _____ Yes _____ No If Yes, please explain.
   _____
   _____
8. Are you now or have you ever been impaired by the use of alcohol, drugs, or any intoxicant or any other physical or mental cause to a degree which interferes with your ability to perform competent and objective professional work?
   _____ Yes _____ No If Yes, please explain.
   _____
   _____

Have you ever been suspended or expelled from an academic institution? Yes ___ No If Yes, please explain.
_____

AFFIRMATION

I understand that if I am granted certification and do not satisfy the CNCB/CCN Continuing Education Requirements in the stated period of time, my certification status could be suspended and/or revoked.

The Importance of Maintaining Certification

As technology improves and research deepens, there will always be new advancements in the healthcare industry. For this reason, it is essential that you stay on top of your training in order to provide patients with the top care possible. The CCN Credential requires on-going maintenance to verify that the practitioner is continuing to update knowledge and skills.

*Attendance at 3 out of 4 IAACN Annual Scientific Symposiums per Recertification cycle.
*Payment of Annual CNCB Maintenance Fee. (No refunds in part or in full).
*Passing score on the Recertification exam in your fifth year via annual study textbooks with contracted Open Book Exam.

_____ **I have read and understand the CCN Maintenance Requirements stated above.**
Initial

By signing and submitting this application, I accept the conditions set forth on The CNCB "CCN Study Guide" booklet concerning the administration of the test, the reporting of the test scores, and the certification process and policies. I certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is made in good faith. I further understand that if any information is later determined to be false, The CNCB reserves the right to revoke any certification that has been granted on the basis thereof. If I send my application to the wrong testing service or do not complete the application properly, resulting in a delay, I will not hold the testing service of The CNCB liable.

_____ _____

Signature **Date**

APPLICATION AFFIDAVIT

I, _____, being duly sworn according to law, do depose to say that all statements in the above Application and attachments are true and accurate to the best of my knowledge and belief. I have read the rules and standards of The CCN Study Guide, The CCN Professional Practice Guidelines, and The CNCB Discipline Policy. I comply with and agree to be bound by them.

I make this application for bona fide certification purposes only and will not disclose any information regarding the content of the examination, test questions, or test materials. I authorize The CNCB to communicate any actual or alleged violations of its rules or standards by me, the status of my application, and the pendency and outcome of any matters involving me to its certificants, state and federal authorities, employers, insurance companies, and other. I consent to and authorize The Clinical Nutrition Certification Board in its discretion to request information relevant to this application and my eligibility, certification, recertification, and review of certification and for any entity to furnish this information to The Clinical Nutrition Certification Board, its officers, directors, employees, committee members, and agents and any person furnishing documents, records and other information relating to my eligibility, certification, recertification, or review of certification, from any and all liability of any nature and kind arising out of furnishing or inspection of documents, records, and other information and any investigation and evaluation made by The Clinical Nutrition Certification Board.

Signature of Applicant_____ Date _____

SWORN AND SUBSCRIBED before me this_____ day of _____, 20____

_____ My Commission Expires:_____
Notary Public

ENDORSEMENT

I verify that the Applicant has fulfilled the Requirements for Certification as set forth by The Clinical Nutrition Certification Board. I have reviewed the Application, and to the best of my knowledge, it is complete.

_____ _____
Designated signature of **Date**
Clinical Nutrition Certification Board
Credentials Office