

NAECB EXAMINATION APPLICATION

Applicants may complete the application process online at www.naecb.org by selecting Examination Application. If you prefer to complete the paper application, please complete all sections of this form. Please include credit card information or enclose a cashier's check or money order payable to AMP for the appropriate amount. Mail the application and fee to:

NAECB Examination, Applied Measurement Professionals, Inc., 8310 Nieman Road, Lenexa, KS 66214-1579.
For further information, you may call the Candidate Services Department at 913/541-0400.

PERSONAL INFORMATION *(please print using black or blue ink)*

Name: _____
(Last, First, Middle)

Social Security Number: _____ Date of Birth: _____

Daytime Telephone Number: _____ Evening Telephone Number: _____

Fax Number: _____ E-mail Address: _____

Street Address: _____

City: _____ State: _____

Zip Code/Postal Code: _____ Country: _____

Eligibility Requirements – Please complete one of the following eligibility requirements:

I am a currently licensed or credentialed health care professional in the following profession (please indicate by checking box):

- Physician (MD, DO)
- Physician Assistant (PA-C)
- Nurse (RN, LPN)
- Respiratory Therapist (RRT, CRT)
- Pulmonary Function Technologist (CPFT, RPFT)
- Pharmacist (RPh)
- Social Worker (CSW)
- Health Educator (CHES)

OR

I am applying for the NAECB Examination with a minimum of 1000 hours experience in asthma education, counseling or coordinating services.

EXAMINATION INFORMATION

I am including a Special Accommodations Request:

- No
- Yes *(Complete the form included in this handbook.)*

I am a: New Applicant
 Reapplicant
 Recertifier

EXAMINATION FEE

Payment may be made by credit card, cashier's check or money order made payable to AMP.

- New Applicant \$275
- Reapplicant \$150
- Recertifier \$275

If payment is made by credit card, complete the following;

- Visa MasterCard
- American Express Discover

Credit Card Number

Expiration Date

Name on Card

Signature

DEMOGRAPHIC QUESTIONS

1. Nature of the Practice setting in which you work:

- University
- Hospital
- Multispecialty Clinic
- Physician Office

2. Number of Hours (per week) in Asthma Education, Coordination or Counseling Services:

- Less than 8 hours
- 8-16 hours
- 17-24 hours
- 25-32 hours
- 33-40 hours
- More than 40 hours

3. Experience as an Asthma Educator, Coordinator or Counselor:

- 0-1 year
- 2-3 years
- 4-5 years
- 6-10 years
- 11-15 years
- 16 years or more

4. Type of Primary Practice Setting:

(check all that apply to your ONE primary practice setting)

- Hospital Inpatient
- Hospital Outpatient
- Both Hospital Inpatient/Outpatient
- Physician's Office
- Community Health Agency
- Academic
- Private Practice
- Nursing Home/Extended Care Facility
- Home Health Agency
- Emergency Department
- Other _____

5. Location of Primary Practice Setting:

- Urban
- Rural
- Suburban

6. Highest Education Level Achieved:

- Diploma (college)
- Associate Degree
- Baccalaureate Degree
- Master's Degree
- Doctoral or Medical Degree

7. How did you hear about Certification?

(check all that apply)

- Professional Journal *(specify)* _____
- Regional Meeting *(specify)* _____
- National Meeting *(specify)* _____
- NAECB Mailing
- NAECB website
- Colleague
- Other _____

SIGNATURE

(Sign and date in ink the statement below.)

I certify that I agree to abide by regulations of the NAECB Program contained in this Handbook. I believe that I comply with all admission policies for the NAECB Examination. I certify that the information I have submitted in this application is complete and correct to the best of my knowledge and belief. I understand that, if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed or voided.

Name (Please Print): _____

Signature: _____ Date: _____