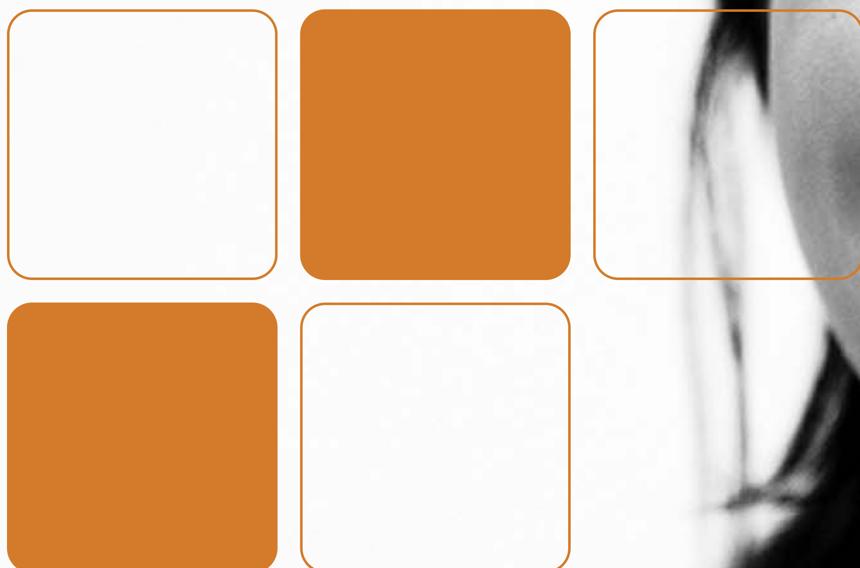
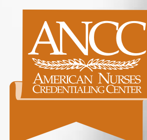
30th Anniversary



Medical-Surgical Nurse Certification Examination



Nursing Excellence: Your Journey - Our Passion

Description of Practice

Nurses in medical-surgical nursing provide care for individuals who have a known or predicted physiological alteration. The practice includes case management and considers all influences on the health status and the related social and behavioral problems arising because due to the patient's physiological condition. Medical-Surgical nursing is practiced in primary, acute, chronic, or long-term care settings.

Medical-Surgical Nurse Eligibility Criteria

(visit www.nursecredentialing.org for more information)

1. Hold a current, active, unrestricted professional RN license in the United States or its territories.
2. Have practiced the equivalent of 2 years full time as a registered nurse in the United States or its territories.
3. Have a minimum of 2000 hours of medical-surgical nursing practice within the last 3-years.
4. Completed 30 contact hours of continuing education in the last 3 years.

Overview of Test Content Outline

(visit www.nursecredentialing.org for an in-depth test content outline, references and sample test questions)

I. Biophysical and Psychosocial Concepts

A. Homeostasis
B. Stress response and compromised immunity
C. Coping and adaptation

II. Pathophysiology of Body Systems

A. Cardiovascular and pulmonary
B. Gastrointestinal, renal, and genitourinary
C. Musculoskeletal, sensorineural, and integumentary
D. Metabolic and endocrine
E. Immunologic and hematologic
F. Multisystem disorders

III. Patient Care Issues

A. Health maintenance, promotion, and restoration
B. Common patient care needs and problems
C. Supervision and coordination of care delivery

IV. Issues and Trends

A. Socioeconomic and cultural issues
B. Research
C. Legal and ethical issues
D. Quality improvement and utilization review
E. Scope and standards of practice
F. Performance appraisal
G. Health care regulations and policies
H. Professional work-related skills

Fees

Member (ANA)	**$180**
Non Member	**$320**

Submit an application, Form D, if applicable transcripts or diploma, and the appropriate fee to:

American Nurses Credentialing Center
P.O. Box 791333
Baltimore, MD 21279-1333

After you file

1. After your application fee is processed, you will receive a Notice of Application Received form.
   - If the information on this form is correct, then place this form with your copy of the application packet.
   - If the information on the form is incorrect, send your changes in writing to the address on the form.
2. If you are eligible to take an exam:
   - You will receive an eligibility-to-test notice from ANCC.
   - An authorization-to-test (ATT) is mailed to you by the testing vendor, Thomson-Prometric.
3. If you are deemed ineligible to take an examination, you will receive a letter stating the reason.

Application for ANCC Initial Certification

ST:
- ☐ E
- ☐ P
- ☐ R
- ☐ QC
- ☐ NE

Instructions: Print legibly using either black or blue ink. An illegible, incomplete, and/or unsigned application creates a delay and may affect your ability to take the examination. Attach all required supporting documents e.g. Professional Development Record, transcripts, etc. and mail to:

ANCC, P.O. Box 791333, Baltimore, MD 21279-1333.

Information on verification of exam eligibility and certification is available on www.nursecredentialing.org

I. General Information

Use your legal name on the application. This name must match photo identification used for examination entry and will be name printed on your certificate.

Last Name | First Name | MI

Home Address | Social Security Number

City | State | Zip Code

Home Phone | Fax | Personal E-Mail

Business Name

Business Address

City | State | Zip Code

Office Phone | Fax | Business E-Mail

NOTE: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Sex ☐ M ☐ F

Date of Birth: ______________________________
(month/date/year)

Race/Ethnic Group: ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic ☐ White/Caucasian ☐ Native Hawaiian/Pacific Islander

1. I have a disability as defined by the American with Disabilities Act (ADA) and require a special accommodation. Call 1800-284-2378 for additional information.

2. Exam title and code: (select one)
☐ **Medical-Surgical Nurse-O4** (AD or Diploma in Nursing)
☐ **Medical-Surgical Nurse-38** (BS or higher degree in nursing. Must attach a copy of transcripts or diploma indicating conferral of the baccalaureate or higher degree in nursing)

3. Indicate the date you plan to take this exam: _____/_____/____
Month Date Year
See www.nursecredentialing.org for exam dates, deadline, and locations.

4. Location:______________________ Site Code:__________
See www.nursecredentialing.org for exam dates, deadlines, and locations.

B. Licensure Information (Attach a copy of license)

1. Current RN License Number: _________________________

State: _____________ Expiration Date: ________________
(month/date/year)

C. Education

Please fill in all boxes that apply.

01 ☐ Diploma	07 ☐ Master's in Other Field
02 ☐ Associate Degree/Other Field	08 ☐ PhD Other Field
03 ☐ Associate Degree in Nursing	09 ☐ EdD
04 ☐ Baccalaureate in Nursing	10 ☐ DNSc
05 ☐ Baccalaureate in Other Field	11 ☐ PhD in Nursing
06 ☐ Master's in Nursing	12 ☐ ND

Graduate Institution: | School Code*

Major: | Date degree conferred:

Post-Graduate Institution: | School Code*

Post-Graduate Major: | Date conferred:

* School codes are available via Fax-on-Demand 1-888-880-2404 Doc #116 or on-line at www.nursecredentialing.org

II. DEMOGRAPHIC DATA - General Information

1. Do you currently hold an ANCC Certification?
☐ Yes ☐ No If "yes" please indicate certification
____

2. Are you certified by other organizations?
☐ Yes ☐ No If yes, please indicate certification credential and organization name/s:
____
____
____

Practice Please fill in all boxes that apply.

1. Primary field/place of employment:

1 ☐ Hospital
2 ☐ Nursing Home/Long-Term Care
3 ☐ Home Health
4 ☐ Nurse-Managed Practice
5 ☐ Independent/Solo Practice/Self-Employed
6 ☐ Public Health/Community Health
7 ☐ School Health
8 ☐ Office Nursing (Mental Health Center)
9 ☐ Occupational /Environmental Health
☐ Federal/Military/VA
10 ☐ Ambulatory Care
11 ☐ HMO/Managed Care
12 ☐ Group Home
13 ☐ School of Nursing/University
14 ☐ Hospice
15 ☐ Per diem/agency/travel nurse
16 ☐ Other: ________________ (Specify)

2. Type of Primary Position

1 ☐ Nurse Manager/Charge Nurse
2 ☐ Staff
3 ☐ Nurse Practitioner
4 ☐ Clinical Nurse Specialist
5 ☐ Administrator/DON/VP Nursing
6 ☐ Associate or Assistant Administrator
7 ☐ Educator
8 ☐ Consultant
9 ☐ Researcher
10 ☐ Case Manager
11 ☐ Other: ________________ (Specify)

3. Years of experience as a registered nurse:

1 ☐ 0-2
2 ☐ 3-5
3 ☐ 6-10
4 ☐ 11-15
5 ☐ 16-20
6 ☐ 21-25
7 ☐ 26-30
8 ☐ 31 or greater

4. Total years of experience in the field in which recertification is desired:

1 ☐ 0-2
2 ☐ 3-5
3 ☐ 6-10
4 ☐ 11-15
5 ☐ 16-20
6 ☐ 21-25
7 ☐ 26-30
8 ☐ 31 or greater

5. Size of facility:

1 ☐ N/A
2 ☐ 1-100
3 ☐ 101-250
4 ☐ 251-500
5 ☐ More than 500

6. Location of facility:

1 ☐ Urban
2 ☐ Rural
3 ☐ Suburban
4 ☐ Outside the U.S.

7. Patient encounters/Patient visits per/year at your primary place of employment:

1 ☐ Less than 1,000
2 ☐ 1,000-5,000
3 ☐ 5,001-10,000
4 ☐ 10,001, 20,000
5 ☐ 20,001-40,000
6 ☐ 40,001-60,000
7 ☐ 60,001-80,000
8 ☐ 80,001-100,000
9 ☐ 100,001 or greater

8. Number of individuals you supervise:

1 ☐ 1-4
2 ☐ 5-10
3 ☐ 11-50
4 ☐ 51-150
5 ☐ More than 150
6 ☐ Not Applicable

9. Patient population – types of patient conditions representative of your practice:

____

10. Patient/client age range:

1 ☐ 0-1
2 ☐ 2-21
3 ☐ 22-65
4 ☐ 66+

11. Number of hours worked per week:

1 ☐ less than 8
2 ☐ 8-16
3 ☐ 17-24
4 ☐ 25-32
5 ☐ 33-40
6 ☐ 41 or greater

12. Do/will you receive any monetary reward for certification? ☐ Yes ☐ No

13. If you answered "yes"" please indicate the amount:

per hour ________________
per year ________________
one time ________________

14. Is certification part of the job performance/ clinical ladder rating criteria? ☐ Yes ☐ No

15. List the professional organization/s of which are a member:

____
____
____

ALL APPLICANTS MUST COMPLETE THIS SECTION - Statement of Understanding

I hereby apply for certification offered by the American Nurses Credentialing Center (ANCC). I understand that I am subject to all requirements of certification as described in this catalog and that certification depends on successfully completing specified program requirements. If certified, my name will be included in the official listing of certified nurses.

I authorize the Commission on Certification to make whatever inquiries and investigations that it deems necessary to verify my credentials and professional standing. I expressly acknowledge that information accumulated by ANCC through the certification process may be used for statistical, research, and evaluation purposes and that the ANCC may enter into agreements to release anonymous and aggregate data to external researchers. Otherwise, subject to the above mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without my permission.

To the best of my knowledge, the information on this application is true, complete and correct. I attest by my signature that I meet all eligibility requirements for certification, in effect for the year in which this application is made as stipulated in the most current catalog. I attest by my signature that I will maintain an active registered nurse licensure throughout the entire period during which I am certified. I understand that any misstatement of any material fact submitted upon application for certification may be sufficient cause for ANCC to bar me from the examination, to invalidate the results of my examination, to withhold certification, to revoke certification, or to take other appropriate action.

(Applications received without a signature incur a delay in processing which will cause a delay in the review of your application and ability to take a certification examination.)

Signature **Date**

Mailing List Authorization

ANCC may release mailing lists from its certification database to organizations or individuals who have information to distribute that would be beneficial to nurses or to nursing and credentialing research. If you do not wish your name and mailing address to be released for marketing purposes, please mark the decline option below.

__ I do not wish my name and mailing address to be released for any marketing purposes.

Payment Method

☐ Personal Check/Money Order (payable to ANCC) Amount Enclosed: ______________

☐ Charge Card (MasterCard or VISA only) Amount to be charged: ____________

Account Number ______________________________________ Exp. Date________________

Print Name on Card ______________________________ Signature ______________________

Form D Professional Development Record

Instructions: Use this form to document your professional development requirements for your certification specialty. Keep copies of continuing education certificates for your records in case you are audited. List in-services, academic credits, CME credits, independent study that has been approved for continuing education and other continuing education related to the nursing specialty. If course titles do not clearly reflect the course's relevance to your practice, include a brief description of how the course impacts your practice.

NOTE: Before completing this form, review the Specific Eligibility Requirements for your specialty.

Candidate's Name (Last, First, MI) **Social Security Number**

Equivalencies:

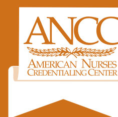
- 1 CEU = 10 contact hours
- 1 contact hour = 50 minutes
- 1 academic quarter hour = 12.5 contact hrs
- 1 contact hour = 0.1 CEU
- 1 academic semester hour = 15 contact hours
- 1 CME = 60 minutes or 1.2 contact hours

Subject Matter/Course Content	Name of Sponsor, Provider or Institution	Date of Offering	Number of Contact/Academic Hours
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
		Total	

Specialty Nursing Certification (Read the statement below and then sign and date)

__ I hereby attest that I meet the eligibility criteria as stated in the most recent version of the catalog and ANCC website for the Medical-Surgical Nurse certification exam. I have practiced the equivalent of 2 years full-time as a registered nurse in the United States or its territories. I have practiced the required hours as stated in the catalog for the specialty certification I am seeking. I have enclosed all forms and other documents as indicated for the specialty certification exam I am seeking.

Signature Date



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American Nurses Credentialing Center
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1-800-284-2378
www.nursecredentialing.org

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