

SKIN AND WOUND MANAGEMENT COURSE REGISTRATION



WOUND CARE
EDUCATION INSTITUTE®



Submit completed application and fees to the Norton School of Lymphatic Therapy:

MAIL

750 State Route 34 – Suite 7
Matawan, NJ 07747

FAX

Fax (866) 854-7800

Please make checks or money orders payable to:

Norton School of Lymphatic Therapy

Or complete the credit card authorization form below

For cancellation policy details please call us toll-free at:
(866) 445-9674

To qualify for the National Alliance of Wound Care® Certification, the attached certification application must be completed in full and accompany registration.

Name (Please print all information legibly)

Home Address Street

City

State

Zip

Current Employer or Facility

Phone

E-Mail (Required for confirmation)

Name and Phone Number of *Emergency Contact During Course*

ADA statement- Please Contact me, I have special needs

Select WCEI COURSE Location

Indicate WCEI Course Location. (Dates and locations listed on www.wcei.net website)

City/State _____

Week of _____ through _____

Select REGISTRATION Type

A \$30.00 non-refundable application fee must accompany each application in order to be processed.

Group rates are for 3 or more attendees registering and submitting payment together by mail.

Any changes or transfers to applications once they have been processed will result in a \$200.00 change fee.

Registration fees include Books, Materials, Lunch, Certification Examination, clinical support.

<input checked="" type="checkbox"/>	Registration (See above)	Cost per Each	How many	Total
	Individual Regular Registration	\$2,597.00		
	Group Regular Registration Group Name: _____	\$2,297.00		
	Application Fee (non-refundable- due at time of registration)	\$30.00		

TOTAL AMOUNT DUE

Credit Card Authorization

I authorize Norton School of Lymphatic Therapy to charge \$ _____ to my:

VISA MasterCard AMEX Discover

Card Number

Expiration Date

Security code*

Cardholder Name

Cardholder Phone

Credit Card Billing Address

City

State

Zip

Cardholder Signature

Date

INTERNAL USE ONLY

DT - AM- AT-

*3-digit code found on signature strip at the end of a series of numbers. 4 Digits for AMEX cards.

- Application Fee Enclosed
- Application & Course Fee Enclosed
- Bill my credit card

Applicant Signature

Date

How did you find out about the WCEI course?

- Post Card/Direct Mail
- Nursing Spectrum/Nurseweek Magazine
- Advance Magazine
- McKnights
- Google Search
- Yahoo Search
- Other Internet Search
- Web Site (Which One?) _____
- Referral (Please Specify) _____
- Other (Please Specify) _____

NATIONAL ALLIANCE OF WOUND CARE® WCC® EXAMINATION APPLICATION



1. PRINT NAME (as it appears on your professional license) Last: _____ First: _____ MI: _____	
2. MAILING ADDRESS Street: _____ City: _____ State/Province: _____ Country: _____ Zip/Postal Code: _____	3. DATE OF BIRTH _____
Daytime Telephone: _____ Evening Telephone: _____ Email (Required for confirmation): _____ () ()	
4. PROFESSIONAL LICENSES (Check all that apply) <input type="checkbox"/> LPN/LVN <input type="checkbox"/> RN <input type="checkbox"/> NP/APN <input type="checkbox"/> OT <input type="checkbox"/> PTA <input type="checkbox"/> PT <input type="checkbox"/> PA <input type="checkbox"/> MD/DO/DPM License Number(s): _____ State: _____ ORIGINAL Issue Date: _____ Expiration Date: _____	5. EDUCATION <input type="checkbox"/> Diploma <input type="checkbox"/> MSN <input type="checkbox"/> Associate <input type="checkbox"/> PhD <input type="checkbox"/> BS <input type="checkbox"/> MD/DO/DPM <input type="checkbox"/> BSN <input type="checkbox"/> Other: _____ <input type="checkbox"/> BA Field of Study: _____
6. BOARD CERTIFICATIONS (Check all that apply) <input type="checkbox"/> CWS/CWCA Certification # _____ <input type="checkbox"/> CWCN Certification # _____ <input type="checkbox"/> CWON Certification # _____ <input type="checkbox"/> CWOCN Certification # _____	7. LICENSED EXPERIENCE/PRACTICE WOUND CARE (Minimum of 2 years must be completed by exam date) <input type="checkbox"/> Two to Five years <input type="checkbox"/> More than Five but fewer than Ten <input type="checkbox"/> Ten or more Years
8. PRIMARY PLACE OF EMPLOYMENT <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient <input type="checkbox"/> Long Term Care <input type="checkbox"/> Education <input type="checkbox"/> Home Care <input type="checkbox"/> Administration <input type="checkbox"/> Independent Consultant <input type="checkbox"/> Sales	9. HOURS WORKED IN WOUND CARE PER WEEK: <input type="checkbox"/> Part Time - 8-20 hours <input type="checkbox"/> Part Time - 21-39 hours <input type="checkbox"/> Full Time - 40 or more
10. EXAMINATION TYPE: <input type="checkbox"/> On Site at WCEI Skin and Wound Management Course COURSE LOCATION: _____ (An acceptance letter and NAWC® Candidate Handbook will be mailed to you with your WCEI course confirmation. If you elect to change your testing site after the confirmation letter is sent, you will be charged an additional \$75 administrative fee.) <input type="checkbox"/> Computerized Testing Center If you elect the Computerized Testing Center option, you will receive a confirmation notice that includes a toll free number for the candidate to contact LaserGrade Computer Testing, Inc. for scheduling the examination at a testing center. A list of available testing centers may be viewed at www.lasergrade.com	11. ADA ACCOMODATION <input type="checkbox"/> YES, special arrangements will be necessary for me to complete the examination. (If yes, contact NAWC for instructions)
<div style="border: 1px solid black; padding: 10px;"> Office Use Only: ELG- Y N ACT- Y N DISP- Y N VER DT- _____ BY- _____ </div>	

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 (You may make copies of this page as needed to document required experience.)



12. WORK EXPERIENCE VERIFICATION

a. Complete the following sections to document required wound care related work experience.

Candidate's Name (Please print) _____

Employer _____

Employer Address _____

Employment Dates From: ___/___/___ to: ___/___/___ Full Time Part Time

Supervisor Name: _____ Supervisor Phone Number: _____

Employer _____

Employer Address _____

Employment Dates From: ___/___/___ to: ___/___/___ Full Time Part Time

Supervisor Name: _____ Supervisor Phone Number: _____

Employer _____

Employer Address _____

Employment Dates From: ___/___/___ to: ___/___/___ Full Time Part Time

Supervisor Name: _____ Supervisor Phone Number: _____

b. This section to be completed by current supervisor.

The individual named above has applied for WCC® certification examination. Eligibility criteria require candidates to document their clinical wound care experience. Please help this candidate to document relevant experience by completing one of the following statements:

I verify that the candidate named above was actively involved in the treatment of wound care patients, or in management, education or research directly related to wound care, while actively licensed, for a MINIMUM of 2 years full-time or 4 years part-time within the past 5 years.

Supervisor Signature

Date

Print Supervisor Name

Supervisor Phone Number

OR

I verify that the candidate named above was actively involved in the treatment of wound care patients, or in management, education or research directly related to wound care, while actively licensed, for a MINIMUM of four years full-time within the past five years.

Supervisor Signature

Date

Print Supervisor Name

Supervisor Phone Number

13. AGREEMENT AUTHORIZATION and CERTIFICATION INFORMATION RELEASE

I hereby affirm that I have been a _____ actively and directly involved in the delivery of wound care or in
(License Type)
Management, Education or Research directly related to wound care for a:

- MINIMUM of two years full-time or four years part-time within the past five years.
or
- MINIMUM of four years full-time within the past five years.

I further affirm that I am currently licensed to practice as a _____ in the state of _____.
(License Type)

I further affirm that no licensing authority has current disciplinary action pending against my license to practice in the aforementioned or any other state, and that my license to practice is not currently suspended, restricted or revoked by any state or jurisdiction.

I authorize the National Alliance of Wound Care® to make whatever inquires and investigations that is deems necessary to verify my credentials and professional standing. I further allow the National Alliance of Wound Care® to use information from my application and subsequent examination for the purpose of statistical analysis, provided my personal identification with that information has been deleted.

I hereby understand the National Alliance of Wound Care® will publish my name, professional license type, city, state, past and present certification status under the NAWC® WCC® Certification Directory, in print and electronic versions of a worldwide directory of NAWC® WCC® Certified Practitioners. I release the NAWC®, its subsidiaries and affiliates and their employees, successors and assigns from any claims of damages for libel, slander, invasion of rights of privacy or publicity, and any other claim based on the publication or release of any Certification Information as specified in this Certification Information Release.

As the applicant, I declare that the foregoing statements are true. I understand false information may be cause for denial or loss of the credential.

Applicant signature

Print Name

Date