

# Ostomy Management Specialist Certification Course Registration and Course Information



## Instructions:

1. Complete and print out the attached application form.
2. Important - Items 1-12 must be completed to be considered for certification eligibility. The course attendee will not be approved to sit for the certification examination if there is any missing or incomplete information on these documents.
3. Submit completed application by mail, fax or email.

Mail to :  
Saint Joseph's College  
278 Whites Bridge Rd  
Standish, ME 04084

Fax to:  
(207) 892-7480 Attn: Stephanie Briggs

Email to:  
sbriggs@sjcme.edu

## Payment:

Price of Course: \$2597.00 Room and Board Optional: \$350 Double or \$400 Single

If paying by check, make check out to Saint Joseph's College and submit with application.

If paying by credit card, you may submit payment:

- 1) Online at [www.sjcme.edu/oms](http://www.sjcme.edu/oms)
- 2) Call 207-893-7769 and submit payment over the phone.
- 3) In person, at Saint Joseph's College 278 Whites Bridge Rd, Standish, ME 04084

**Applications will not be processed until payment is received.**

## Course Location

Saint Joseph's College  
Alfond Hall  
278 Whites Bridge Rd  
Standish, ME 04084

## Course Info DATE:

July 16-20, 2018

Registration/Check-In on Monday from 8:00am-9:00am

Class training sessions will be held Monday - Thursday, 9:00-4:30pm and are taught by the

Wound Care Education Institute® instructors.

Wound Care Certification examination will be given on Friday 8:00am by the National Alliance of Wound Care and Ostomy®.

- Participant must attend all class sessions to be eligible for certification examination.
- Participant must attend all class sessions to be eligible for continuing education credits.
- Registration fees cover all class materials.

Find out more information about the Wound Care Education Institute at [www.wcei.net](http://www.wcei.net)

Find out more information about the National Alliance of Wound Care and Ostomy at

[www.nawccb.org](http://www.nawccb.org)



**NATIONAL ALLIANCE OF WOUND CARE AND OSTOMY®**  
**NAWCO® EXAMINATION ONSITE APPLICATION**

National Alliance of Wound Care  
and Ostomy®

*Missing or incomplete information will delay Application processing*

<b>1. PRINT NAME:</b> (As listed on your Professional License) LAST: _____ FIRST: _____ MIDDLE: _____		
<b>2. MAILING ADDRESS:</b> STREET: _____		<b>3. DATE OF BIRTH:</b> MM/DD/YYYY: _____
CITY: _____	STATE / PROVINCE: _____	COUNTRY: _____
ZIP / POSTAL CODE: _____		
DAYTIME TELEPHONE #: _____	EVENING TELEPHONE #: _____	E-MAIL: <b>REQUIRED FOR CONFIRMATION</b>
<b>4. PROFESSIONAL LICENSES:</b> (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): _____  Issuing State: _____ <b>ORIGINAL</b> Issue Date: _____  Expiration Date: (mm/dd/yyyy): _____	<b>5. EDUCATION:</b> <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: _____	
<b>6. WOUND CARE CERTIFICATIONS:</b> (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 #: _____	<b>7. LICENSED EXPERIENCE / PRACTICE IN WOUND CARE:</b> 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	
<b>8. PRIMARY PLACE OF EMPLOYMENT:</b> <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"/> Sales <input type="checkbox"/> Independent Consultant	<b>9. ADA ACCOMMODATION:</b> <input type="checkbox"/> YES Special arrangements will be necessary for me to complete the examination. (If yes, contact NAWCO® for instructions.)	
<b>10. EXAMINATION TYPE:</b> <input type="checkbox"/> On Site at WCEI® Skin and Wound Management Course Course Location: <u>Saint Joseph's College Maine</u> Course Dates: <u>June 11-15, 2018</u> (An acceptance letter and NAWCO® Candidate Handbook will be emailed to you with your WCEI® course confirmation. If you elect to change your testing site after the confirmation is sent, you will be charged an additional \$75.00 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 PSI Computer Testing, Inc. for scheduling the examination at a testing center. A list of available testing centers may be viewed at <a href="http://www.psiexams.com">www.psiexams.com</a>	<b>Office Use Only:</b>  ELG: Y N  ACT: Y N  DISP: Y N  VER DT: _____ BY: _____  ID: _____	



**11. WORK EXPERIENCE VERIFICATION**

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

Candidate's Name: (Please Print) \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: (Street, City, State & Zip) \_\_\_\_\_

Employment Dates: From \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Current Employer  
 Full Time  Part Time  
*You Must Specify Full or Part Time*

Supervisor Name: \_\_\_\_\_ Supervisor Telephone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: (Street, City, State & Zip) \_\_\_\_\_

Employment Dates: From \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Current Employer  
 Full Time  Part Time  
*You Must Specify Full or Part Time*

Supervisor Name: \_\_\_\_\_ Supervisor Telephone #: \_\_\_\_\_

**12. AGREEMENT AUTHORIZATION and CERTIFICATION INFORMATION RELEASE**

I hereby affirm that I have been a(n) \_\_\_\_\_ actively and directly involved in the delivery of wound care or in 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.

I further affirm that I am currently licensed to practice as a(n) \_\_\_\_\_ in the state of \_\_\_\_\_.

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 and Ostomy™ to make whatever inquiries and investigations deemed necessary to verify my credentials and professional standing. I further allow the National Alliance of Wound Care and Ostomy™ 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 and Ostomy™ will publish my name, professional license type, city, state, past and present certification status under the NAWCO® WCC® Certification Directory, in print and electronic versions of a worldwide directory of NAWCO® WCC® Certified Practitioners. I release the NAWCO®, 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's Digital Signature Acknowledges Agreement and Verification of the Information Provided.***

\_\_\_\_\_  
 Applicant Signature \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name