



## ABCGN Certification Examination Application

### 3 Easy Steps to Apply:

1. Visit our website, [www.abcgcn.org](http://www.abcgcn.org), and print off the Certification Exam Handbook. Please review before sending in your application.
2. Complete the Certification Application and attach a copy of your nursing license, prominently marked "Copy" and your membership number if submitting SGNA member discounted fees.
3. Send the application and all supporting documentation via CERTIFIED MAIL, return receipt requested to insure your application has been received.

### Eligibility Requirements:

ABCGN certification is open to Registered Nurses in GI. At the time of application, a candidate must have been employed in a clinical, supervisory, administrative, teaching/education and/or research capacity in the field of gastroenterology in an institutional or private practice setting for a minimum of two years full-time, or its part-time equivalent of 4000 hours, within the past five years. Work experience must be at the level the candidate is certifying for. Verification of licensure and work experience is required.

Applying for:  Initial Certification       Recertification

Test Site 3-Digit Code (For Computer Based Testing write "CBT"): \_\_\_\_\_ City \_\_\_\_\_

### Contact Information:

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Nighttime Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_ E-Mail Address \_\_\_\_\_

### Demographic Information

- |  |  |   |
|--|--|---|
| <p>1. Highest Education Level</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Diploma in Nursing</li><li><input type="checkbox"/> Associate's Degree/Nursing</li><li><input type="checkbox"/> Bachelor's Degree/Nursing</li><li><input type="checkbox"/> Master's Degree</li><li><input type="checkbox"/> Doctoral Degree</li><li><input type="checkbox"/> Other _____</li></ul> <p>2. Primary Place of Employment</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Hospital</li><li><input type="checkbox"/> Clinic</li><li><input type="checkbox"/> Private Office</li><li><input type="checkbox"/> Ambulatory Center</li></ul> <p>3. Hours Worked Per Week:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Part-Time 20 hours or less</li><li><input type="checkbox"/> Part-Time more than 20 hours</li><li><input type="checkbox"/> Full-Time</li></ul> | <p>4. Years of Gastroenterology Experience</p> <ul style="list-style-type: none"><li><input type="checkbox"/> 2-5 years</li><li><input type="checkbox"/> 6-10 years</li><li><input type="checkbox"/> 11-15 years</li><li><input type="checkbox"/> 16-20 years</li><li><input type="checkbox"/> 21-25 years</li><li><input type="checkbox"/> 26 or more years</li></ul> <p>5. Have you participated in a certification review course?</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes</li><li><input type="checkbox"/> No</li></ul> <p>If yes, when and where?<br/>_____</p> | <p>7. The following will be used for demographic purposes only. Your response is optional but appreciated.</p> <p>Gender:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Male</li><li><input type="checkbox"/> Female</li></ul> <p>Ethnicity:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Asian</li><li><input type="checkbox"/> African American</li><li><input type="checkbox"/> Caucasian</li><li><input type="checkbox"/> Hispanic</li><li><input type="checkbox"/> Native American</li><li><input type="checkbox"/> Other _____</li></ul> <p>Age Range:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Under 25</li><li><input type="checkbox"/> 25-29</li><li><input type="checkbox"/> 30-39</li><li><input type="checkbox"/> 40-49</li><li><input type="checkbox"/> 50-59</li><li><input type="checkbox"/> 60 and above</li></ul> |
| <p>6. Is this the first time you have taken the Certification Exam?</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes</li><li><input type="checkbox"/> No</li></ul>   |  |   |

**Verification of Professional Qualifications:**

Verification of professional qualification is required for all candidates. This must be completed by two responsible practitioners in the gastroenterology/endoscopy specialty.

1. Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Organization: \_\_\_\_\_

I certify that to the best of my knowledge the list work experience is correct and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Organization: \_\_\_\_\_

I certify that to the best of my knowledge the list work experience is correct and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Work History:**

Present Employer

Organization: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Year/Months Worked: \_\_\_\_\_

Previous Employment:

Organization: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Year/Months Worked: \_\_\_\_\_

Organization: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Year/Months Worked: \_\_\_\_\_

Organization: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Year/Months Worked: \_\_\_\_\_

- I affirm that the information contained in this application is true:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information on a candidate's certification status and renewal date, as well as any suspensions or revocations of certification status, will be released by ABCGN upon request to any public entity or agency. By signing this application, the candidate is providing authorization for release of name and certification status. Personal information outside of certification status can only be accessed and/or released by the candidate.

**Payment Information:** *fees subject to change*

Examination Fee SGNA Member- \$300 (paper and pencil)	\$400 (Computer Based Testing)
Examination Fee Non-SGNA Member- \$385 (paper and pencil)	\$485 (Computer Based Testing)

Late Registration deadline application will be assessed a \$50 late fee.

*ABCGN application fees are non-cancelable and non-transferable. No refunds will be given.  
Please refer to the Certification Handbook for the official Refund and Rollover policies.*

**Method of Payment:**

SGNA Member:  Yes  No

Applicants Name: \_\_\_\_\_

Check made payable to ABCGN enclosed for {amount}: \_\_\_\_\_

Charge to credit card {check one}:  Visa  MasterCard  American Express

Name as it appears on the card: \_\_\_\_\_

Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Please mail your completed application and payment to:

**ABCGN Certification Exam  
1967 Paysphere Circle  
Chicago, IL 60674**

**Phone: 800-245-7462 option 3  
Fax: 312-673-6723  
Email: [info@abcdn.org](mailto:info@abcdn.org)  
Web: [www.abcdn.org](http://www.abcdn.org)**