Skin & Wound Management Rertification 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 with payment to:

   The University of Louisiana at Monroe
   Continuing Education
   700 University Avenue
   Library 109
   Monroe, LA 71209

Payment:

Price: $1300.00

If paying by check, make check out to University of Louisiana and submit with application.

If paying by credit card, you may submit payment:

1) Online at www.ce.ulm.edu
2) Call 318.342.1030 and submit payment over the phone.
3) In person, at Continuing Education Department Room "University Library 109"

Course Location

University of Louisiana at
Monroe 700 University Avenue
Library 106
Monroe, LA 71209

Course Info

DATE: June 11-14, 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.

- Recertification Participant must attend all class sessions Monday-Thursday ONLY - NO EXAM REQUIRED
- 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
Find out more information about the National Alliance of Wound Care and Ostomy at www.nawccb.org

National Alliance of Wound Care and Ostomy®

ULM - Monroe LA - June 11-14, 2018

WOUND CARE CERTIFIED WCC®

ONSITE RECERTIFICATION BY TRAINING APPLICATION

PROFESSIONAL INFORMATION: ***Missing or incomplete Information will delay Application processing***

1. PRINT NAME: (As listed on your Professional License)

LAST: FIRST: MIDDLE:

2. MAILING ADDRESS: STREET

3. DATE OF BIRTH:

CITY: STATE / PROVINCE: COUNTRY: ZIP / POSTAL CODE:

DAYTIME TELEPHONE #: EVENING TELEPHONE #: E-MAIL: **REQUIRED FOR CONFIRMATION**

4. CURRENT EMPLOYER:

5. PRIMARY PLACE OF EMPLOYMENT: ☐ Hospital ☐ Outpatient ☐ Long Term Care ☐ Education ☐ Home Care ☐ Administration ☐ Sales ☐ Independent Consultant ☐ Other:______________

6. PROFESSIONAL LICENSES: (Check all that apply)

☐ LPN / LVN ☐ RN ☐ NP / APN ☐ OT ☐ PTA ☐ PT ☐ PA
☐ MD / DO / DPM

License Number(s): ______________________ Issuing State: ___________

ORIGINAL Issue Date: ______________ Expiration Date: ______________

OFFICE USE:
ELG: Y N
ACT: Y N
DISP: Y N
VER DATE/BY:
ID:

7. WOUND CARE CERTIFICATIONS: (Check all that apply)

☐ WCC Certification #: _______________ Issue Date: __________ Expiration: __________
☐ CWS / CWCA Certification #: _______________ Issue Date: __________ Expiration: __________
☐ CWCN Certification #: _______________ Issue Date: __________ Expiration: __________
☐ CWON Certification #: _______________ Issue Date: __________ Expiration: __________
☐ CWOCN Certification #: _______________ Issue Date: __________ Expiration: __________
☐ OTHER Credential: __________________________ Certifying Organization: ______________
Certification #: ____________________________ Issue Date: __________ Expiration: __________

8. RECERTIFICATION AGREEMENT AND INFORMATION RELEASE:

By submitting this WCC® Recertification Application, I acknowledge that all supporting documentation provided is true and accurate. If the activities listed on the WCC® Activity Report or the supporting verification documents are falsified in any fashion, I understand that this will result in the revocation of my WCC® credential.

I 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 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® Certification Board 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™ Certification Board to use information from my application for the purpose of statistical analysis, provided my personal identification with that information has been deleted.

I have read and understand all the information provided in the NAWC® recertification handbook. I further agree to abide by the policies and procedures as set forth in the NAWCO® recertification handbook and all conditions included in the NAWCO® candidate recertification agreement.

For listing in the National Alliance of Wound Care and Ostomy® Directory, I hereby authorize the National Alliance of Wound Care and Ostomy®, its licensees, successors, and assigns (collectively "NAWCO®") the right to publish and release my name, past and present certification status under the NAWCO® WCC® Certification Directory, and state/province (collectively "Certification Information") 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.

Applicant's Digital Signature Acknowledges Agreement and Verification of the Information Provided.

_______________________________________ ______________
Applicant Signature Date

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Printed Name