Diabetic Wound Management Certification
Registration and Course Information

Instructions:

1) Print out and complete the attached application form.
2) Important - Items 1-16 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: $2500.00

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 "Library 109"

Course Location

University of Louisiana at Monroe
700 University Avenue
Monroe, LA 71209
Room Number:

Course Info

DATE: March 2-6, 2015
Class training sessions will be held Monday - Thursday, 8:00-5:00pm 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.

- 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
Find out more information about the National Alliance of Wound Care at www.nawccb.org

NATIONAL ALLIANCE OF WOUND CARE AND OSTOMY™
DIABETIC WOUND CERTIFIED (DWC™)
ONSITE EXAMINATION APPLICATION

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:

MM/DD/YYYY:

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

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

4. COURSE LOCATION: (Dates and locations listed on www.wcei.net web site)
Indicate the Diabetic Certification Training program location you plan to attend

City / State: Monroe, LA

Week of: March 2 - 6, 2015

5. ADA ACCOMODATION:

☐ YES

Special arrangements will be necessary for me to complete the examination.
(If yes, contact NAWCO® for instructions.)

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: (mm/dd/yyyy): _____

7. EDUCATION:

☐ Diploma ☐ MSN
☐ Associate ☐ PhD
☐ BS ☐ MD / DO/ DPM
☐ BSN ☐ Other:
☐ BA _____

Field of Study: _____

8. WOUND CARE CERTIFICATIONS: (Check all that apply – If you are currently certified in Wound Care #11 Work Experience Verification is not necessary)

☐ WCC Certification #: _____ Date of Initial Certification: _____

☐ CWS Certification #: _____ Date of Initial Certification: _____

☐ CWCN Certification #: _____ Date of Initial Certification: _____

☐ CWON Certification #: _____ Date of Initial Certification: _____

☐ CWOCN Certification #: _____ Date of Initial Certification: _____

9. PRIMARY PLACE OF EMPLOYMENT:

☐ Hospital ☐ Outpatient ☐ Long Term Care

☐ Education ☐ Home Care ☐ Administration

☐ Sales ☐ Independent Consultant

10. EXPERIENCE / PRACTICE IN WOUND CARE SINCE WOUND CARE CERTIFICATION:

☐ Less than One Year
☐ One to Two Years
☐ Two to Five Years
☐ More than Five but fewer than Ten
☐ Ten or more Years

Office Use:

ELG: Y N CERT ISSUE: VER DATE:
ACT: Y N CERT EXP: INITIALS:
DISP: Y N ID:

11. WORK EXPERIENCE VERIFICATION – To Be Completed ONLY if you are NOT currently Wound Care Certified

Complete the following section(s) to document required **2 YEARS** full-time or 4 YEARS part-time within the past 5 years of active involvement in the care of diabetic patients, or in management, education or research directly related to diabetes.

Name: (Please Print)_____

Employer Name: _____

Employer Address: (Street, City, State & Zip)_____

☐ Current Employer

Employment Dates: From_____ -_____-_____to_____-_____-_____ ☐ Full Time ☐ Part Time

You Must Specify Full or Part Time

Supervisor Name:_____Supervisor Telephone #:_____

Employer Name: _____

Employer Address: (Street, City, State & Zip)_____

☐ Current Employer

Employment Dates: From_____ -_____-_____to_____-_____-_____ ☐ Full Time ☐ Part Time

You Must Specify Full or Part Time

Supervisor Name:_____Supervisor Telephone #:_____

12. AGREEMENT AUTHORIZATION and CERTIFICATION INFORMATION RELEASE

a. I hereby affirm that I have been a(n)_____actively and directly involved in the care of diabetic patients, or in Management, Education or Research directly related to diabetes while actively licensed for at least two (2) years full-time or four (4) years part-time within the past five (5) years.
-OR-
Currently hold an accredited certification in wound care.

b. I further affirm that I am currently licensed to practice as a(n)_____in the state of_____.

c. 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 Wound Care Education Institute and 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® DWC™ Certification Directory, in print and electronic versions of a worldwide directory of NAWCO® DWC™ 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