Application for Recertification of
Multiple Sclerosis Certified Nurses through Learning Activities

***MARKING INSTRUCTIONS:** This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided.* → A B C D E F 1 2 3 4 5 6

Candidate Information

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

First Name | Middle Initial

Last Name | Suffix (Jr., Sr. , etc.)

Number and Street | Apartment Number

City | State/Province

Country

Zip/Postal Code | Telephone Number

Email Address (Please enter only ONE email address. Use two lines if your email address does not fit in one line.)

Current RN License Number | Most Recent MSCN Certificate Number (required)

State/Province/ Country: _____

Date of Initial Certification: ___ / ___ (Month / Year)

Date of Most Recent Certification (if applicable): ___ / ___ / ___ (Day / Month / Year)

Date of Expiration: _____

Credentials

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. PERCENT OF WORKING TIME CURRENTLY SPENT IN MULTIPLE SCLEROSIS NURSING:

○ Less than 20% ○ 51 to 80%
○ 20 to 50% ○ More than 80%

HOW MUCH OF YOUR TIME SPENT IN MULTIPLE SCLEROSIS NURSING IS SPENT IN THE FOLLOWING:

1. **CLINICAL PRACTICE:**
   ○ Less than 25% ○ 25 to 50% ○ More than 50%
2. **ADMINISTRATION:**
   ○ Less than 25% ○ 25 to 50% ○ More than 50%
3. **EDUCATION:**
   ○ Less than 25% ○ 25 to 50% ○ More than 50%
4. **RESEARCH:**
   ○ Less than 25% ○ 25 to 50% ○ More than 50%

B. YEARS OF EXPERIENCE IN MULTIPLE SCLEROSIS NURSING:

○ Less than 2 ○ 10 to 15
○ 2 to 3 ○ 15 to 20
○ 4 to 5 ○ More than 20
○ 6 to 10

C. HIGHEST ACADEMIC LEVEL ATTAINED:

○ Associate Degree ○ Doctorate (Nursing)
○ Bachelor's Degree (Nursing) ○ Doctorate (Nonnursing)
○ Bachelor's Degree (Nonnursing) ○ Certificate
○ Master's (Nursing) ○ Other
○ Master's (Nonnursing)

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Eligibility and Background Information

D. PRIMARY PRACTICE SETTING: *(Darken only one response.)*

- ○ Rehabilitation Center
- ○ Hospital
- ○ Multiple Sclerosis Center or Clinic
- ○ Home or Community Care
- ○ Nursing Home
- ○ Pharmaceutical or Other Commercial Organization
- ○ Research Facility
- ○ Academic

E. MEMBER OF IOMSN OR IOMSN AFFILIATE?

○ No ○ Yes

Note: *Membership in IOMSN is not required.*

F. PRIMARY LANGUAGE:

○ English ○ Spanish ○ German ○ Other
○ French ○ Italian ○ Dutch

G. HAVE YOU ATTENDED AN MS NURSING COURSE DURING THE PAST YEAR?

○ No ○ Yes

H. INDICATE YOUR OPTION FOR RECERTIFICATION THROUGH LEARNING ACTIVITIES:

- ○ Option 2: 75 LA hours
- ○ Option 3: 50 LA hours AND 1000 practice hours

I. RECORD TOTAL NUMBER OF LEARNING ACTIVITIES HOURS FROM PAGE 3.

TOTAL LA HOURS: ☐☐☐

J. IF OPTION 3 FROM QUESTION H WAS SELECTED, RECORD TOTAL NUMBER OF MS PRACTICE HOURS FROM PAGE 4.

TOTAL MS PRACTICE HOURS: ☐☐☐☐

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your recertification.

Race:

- ○ African American
- ○ Asian
- ○ Hispanic
- ○ Native American
- ○ White
- ○ Other

Age Range:

- ○ Under 25
- ○ 25 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 60+

Gender:

- ○ Male
- ○ Female

Candidate Signature

COMPLETE ENTIRE APPLICATION BEFORE SIGNING BELOW.

I have read the Guidelines for Recertification and understand I am responsible for knowing its contents. I certify that the information given in this Application is in accordance with the Guidelines and is accurate, correct, and complete. I give permission to the MSNICB to use demographic information in this Application solely for statistical purposes in supporting recertification.

CANDIDATE SIGNATURE: _____ ***DATE:*** _____

CREDIT CARD PAYMENT *If you want to charge your application fee on your credit card provide all of the following information.*

Name (as it appears on your card): _____

Address (as it appears on your statement): _____

_____

Charge my credit card for the total fee of: $ ☐☐☐☐

Expiration date (month/year): ☐☐ / ☐☐☐☐

Card type: ○ Visa ○ MasterCard ○ American Express

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

SIGNATURE: _____

FOR OFFICE USE ONLY
1171
Date

Fee: ☐☐☐☐

☐ CC ☐ Check

☐☐☐☐☐☐

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☐☐☐☐

APPLICATION FOR RECERTIFICATION OF MULTIPLE SCLEROSIS CERTIFIED NURSES THROUGH LEARNING ACTIVITIES – CONTINUED

Directions: To recertify through learning activities (LA), the candidate must document either 75 MS learning activity hours over the five-year certification term OR 50 MS learning activity hours and 1000 MS practice hours over the five-year certification term. Each LA must be relevant to MS. Not all LA hours must be nursing activities, but all LA hours should promote improved knowledge and/or skills in MS nursing. If you repeat an identical LA during the five-year certification term, it can only be counted once. Subtract the time taken for breaks, lunch, etc. from your LA. ALL LA hours must be earned during the five-year certification term. Pre-authorization from IOMSN is not required for your LA to count. All MSCNs are responsible for maintaining learning activities documentation used for this Application. All Applications are subject to audit and may be randomly selected for verification of the information provided. Candidates whose Applications are selected for audit will be notified on receipt of Application and will be requested to document all entries.

LEARNING ACTIVITIES (These may include academic courses, conferences, seminars, workshops, internet offerings, in-service, examination development, MS patient care, independent study, preceptorship, research, publication, poster presentation, presenter/lecturer, and professional committee membership/participation. Refer to the Guidelines for Recertification for the number of LA hours permitted for each category. Candidates must have written documentation of the number of hours for each program completed. List programs in date order, beginning with the most recent. Print or type all information.)

Item No.	Learning Activity (LA): Type of activity, name/title (e.g., conference, course, research, presentation)	Name of Organization, Program Sponsor, Journal, Publisher, Committee	Date	No. of Hours	Office Use Only
Example 1	Conference, CMSC 2003 "Spectrum in MS Care"	BioSymposia Inc.	May 28-June 1, 2003	23.5 hours	
Example 2	Research "Quality of Life in MS Patients Living with Chronic Pain"	University Hospital	July 2002-June 2004	15 hours (maximum allowed)	

List additional LAs on separate sheet of paper, if needed. Enclose with but do not staple to Application.

ENTER TOTAL NUMBER OF HOURS OF LEARNING ACTIVITIES:_____

APPLICATION FOR RECERTIFICATION OF MULTIPLE SCLEROSIS CERTIFIED NURSES THROUGH LEARNING ACTIVITIES – CONTINUED

MULTIPLE SCLEROSIS PRACTICE HOURS (Multiple sclerosis nursing practice hours include clinical practice, consultation, research, administration, or education related to the field of multiple sclerosis. To apply through option 3, one must submit 50 learning activity hours AND 1000 MS practice hours over the five-year certification term. Candidates must have written documentation of the number of hours for each program completed. List practice hours in date order, beginning with the most recent. Print or type all information.)

Full Name of Employer/Hospital and Address	Title/Responsibilities	Dates of Employment From mm/yy to mm/yy	Total Number of Practice Hours

List additional MS Practice Hours on separate sheet of paper, if needed. Enclose with but do not staple to Application.

Before signing Candidate Affirmation, PRINT your name and number exactly as they appear on your current certificate.

ENTER TOTAL NUMBER OF MS PRACTICE HOURS: _____

_____

Name (PRINT) MSCN Number

CANDIDATE AFFIRMATION/AUTHORIZATION

I affirm that all statements given on this Application are true and correct to the best of my knowledge and that the MSNICB is hereby authorized to contact any organization or individual listed hereon to verify my Learning Activities history.

_____

Signature of MSCN Date

_____

Current Registered Nurse License Number State

****APPLICATION CHECKLIST****

_____ Pages 1 and 2; completed and signed
_____ Pages 3 and 4; completed and signed
_____ Appropriate Fee enclosed: $300.00
_____ Late administration fee for applications submitted after application deadline: $75.00