

# GUIDELINES FOR CORLN RECERTIFICATION THROUGH CONTINUING EDUCATION IN OTORHINOLARYNGOLOGY AND HEAD-NECK NURSING

## QUALIFICATION CRITERIA

To apply for recertification through continuing education, 100 contact hours (CH) of continuing education **related to otorhinolaryngology and head-neck nursing practice** must be submitted for consideration. All CHs must have been completed during the five years prior to the candidate's certification renewal date and may be accumulated in any combination of continuing education programs.

The continuing education programs may include workshops, seminars, professional development offerings, home-study courses, and state or national conferences. The continuing education offering must be provided by or approved for contact hours by the Society of Otorhinolaryngology and Head-Neck Nursing (SOHN) or another organization accredited by the American Nurses Credential Center's Commission on Accreditation. 100 points can be earned through ORL nursing contact hours or you can have a combination of the following:

1. Maximum of 25 ENT-based CMEs in five years.
2. 10 points for an original clinical referenced article published in ORL-Head and Neck Nursing (maximum of one article in five years).
3. National presentations at the SOHN spring or fall conferences – 5 points each. Two allowed in five-year period for maximum of 10 points.

The candidate may be requested to show proof of contact hours submitted.

All program information must be listed on the Application for CORLN Recertification through Continuing Education in Otorhinolaryngology and Head-Neck Nursing and must include date, program title, provider or sponsor, and number of CHs awarded. If criteria are acceptable, a new five-year certificate will be issued to the CORLN.

**DEADLINES:** Applications for recertification must be postmarked at least two (2) months prior to certification expiration date or candidates must take the Certification Examination in Otorhinolaryngology and Head-Neck Nursing to maintain CORLN status.

Recertification may be denied for failure to meet 100 contact hours, falsification or misrepresentation of information, failure to apply before deadline, or failure to verify information when proper documentation is requested. Recertification will be denied to any candidate who does not have a current RN license. All applications are subject to potential audit. Selection of applications for audit will be made upon their receipt and the candidate will receive written notice of the audit at that time. In the event of an audit, copies of certificates will be requested.

The Appeals Committee of the National Certifying Board for Otorhinolaryngology and Head-Neck Nurses (NCBOHN) provides the appeal mechanism for challenging the denial of recertification. It is the responsibility of the candidate to initiate the process in writing.

If certification lapses, a candidate must meet current eligibility requirements and take the Certification Examination for Otorhinolaryngology and Head-Neck Nursing.

Applications for CORLN Recertification through Continuing Education are available from Professional Testing Corporation, 1350 Broadway, Suite 800, New York, New York 10018, (212) 356-0660, FAX (212) 356-0678, or [www.ptcny.com](http://www.ptcny.com).

**COMPLETION OF APPLICATION**

**NOTE:** A # 2 pencil or black or blue ink may be used to complete the Application.

**PAGES 1 and 2**

In the **Candidate Information Box** on page 1 of the Application, print your name, complete address and telephone numbers in the rows of empty boxes, as shown in the marking sample.

**IMPORTANT:** At the bottom of the Candidate Information box, indicate the date(s) of your original NCBOHN certification and (if applicable) recertification, then enter your RN license information, including State and expiration date.

The **Eligibility and Background Information Box** beginning on page 1 of the Application contains a series of questions identified by the letters A, B, C, D, etc. Fill in the oval that reflects your response to each question. **NOTE:** All questions must be answered.

Be certain to fill the corresponding ovals completely. Do not make x's, dots, circles, or check marks, but fill the oval completely making your marks dark.

**OPTIONAL INFORMATION:** The information requested on page 2 relating to race, age and gender is optional. It is requested to assist in complying with equal opportunity guidelines. It will be used only in statistical summaries and will in no way affect your recertification.

**CANDIDATE SIGNATURE:** Sign and date the application in the space provided on page 2.

**PAGES 3 and 4**

Following the directions on pages 3 and 4, complete Sections A and B in full.

Sign and date the authorizing statement in Section C on page 4. **NOTE:** Unsigned applications will not be accepted. Mail the completed application with the appropriate fee to:

**CORLN RECERTIFICATION  
Professional Testing Corporation  
1350 BROADWAY, SUITE 800  
NEW YORK, NY 10018**

**FEES**

Application fee for CORLN Recertification through Continuing Education in Otorhinolaryngology and Head-Neck Nursing:

SOHN Member .....	\$325.00
Non- SOHN Member .....	\$425.00

**Credit cards: Please complete the credit card section on Page 2 of the Application.**

**Note: There will be no refunds of recertification application fees.**



# Application for CORLN Recertification through Continuing Education in Otorhinolaryngology and Head-Neck Nursing

Page 1

**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
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## Candidate Information

☐ Mr.  
☐ Mrs. First Name  
☐ Ms.  
☐ Dr.

Middel Initial

Last Name

Suffix (Jr., Sr., etc.)

Number and Street

Apartment Number

City

State/Province

Zip/Postal Code

Daytime Phone

Evening Phone

Email Address

Date of Initial Certification

Date of Most Recent Recertification

Current RN License Number:

Month / Year

Month / Year

Month / Year

License State: License Expiration (Month/Year)

Month / Year

## Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

**A. PERCENT OF WORKING TIME CURRENTLY SPENT IN OTORHINOLARYNGOLOGY AND HEAD-NECK NURSING:**

- ☐ Less than 25%    ☐ 51 to 75%  
☐ 25 to 50%    ☐ More than 75%

**B. EXPERIENCE IN OTORHINOLARYNGOLOGY AND HEAD-NECK NURSING:**

- ☐ Less than 3 years    ☐ 4 - 5 years    ☐ More than 10 years  
☐ 3 years    ☐ 6 - 10 years

**C. HIGHEST ACADEMIC LEVEL ATTAINED:**

- ☐ Associate Degree in Nursing  
☐ Diploma in Nursing  
☐ Bachelor's Degree in Nursing  
☐ Bachelor's Degree (non-Nursing)  
☐ Master's Degree in Nursing  
☐ Master's Degree (non-Nursing)  
☐ Doctoral Degree

**D. PRIMARY AREA OF NURSING PRACTICE:**

- ☐ Otorhinolaryngology  
☐ Head-Neck  
☐ Otorhinolaryngology and Head-Neck  
☐ Otology and Neurotology  
☐ Pediatric Otorhinolaryngology  
☐ Surgery  
☐ Other

**E. PRIMARY PRACTICE SETTING:**

(Darken only one response.)

- ☐ Private or Group Physician Practice  
☐ Hospital/Clinic  
☐ Ambulatory Surgery Center  
☐ Managed Care Facilities (i.e. HMO, PPO)  
☐ Home Health/Hospice  
☐ Academic Institution  
☐ Governmental  
☐ Self-employed  
☐ Other

**F. PRIMARY ROLE: (Darken only one response.)**

- ☐ Staff Nurse  
☐ Office Nurse  
☐ Manager/Administrator  
☐ Educator  
☐ Advanced Practitioner (i.e. CNS, NP)  
☐ Other

**G. MEMBER OF SOHN:**

- ☐ No    ☐ Yes

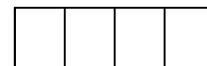
**H. RECORD TOTAL NUMBER OF CONTACT HOURS FROM PAGE 4.**

Total Contact Hours:

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(Continue on page 2)

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# Application for CORLN Recertification through Continuing Education in Page 2 Otorhinolaryngology and Head-Neck Nursing

## 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    ☐ Native American  
☐ Asian    ☐ White  
☐ Hispanic    ☐ No Response

### Age Range:

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

### Gender:

- ☐ Male  
☐ Female

## Candidate Signature

I have read the the Guidelines for CORLN Recertification through Continuing Education in Otorhinolaryngology and Head-Neck Nursing and understand I am responsible for knowing it's contents. I certify that the information given in this Application is in accordance with Guidleines instructions and is accurate, correct, and complete.

**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: \$ \_\_\_\_\_

Card type: ☐ Visa    ☐ MasterCard    ☐ American Express

Expiration date (month/year): \_\_\_\_\_ / \_\_\_\_\_

Card Number: \_\_\_\_\_

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

### FOR OFFICE USE ONLY

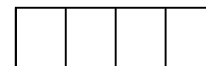
Date

Fee: \_\_\_\_\_

☐ CC    ☐ Check

\_\_\_\_\_

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**A. CONTINUING EDUCATION PROGRAMS:** These may include workshops, seminars, professional development offerings, home-study courses, and state or national conferences approved or provided by SOHN or another ANCC accredited organization. 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.

[illegible]

**ENTER TOTAL NUMBER OF HOURS OF CONTACT HOURS:** \_\_\_\_\_

CONTINUE ON PAGE 4

Mo/Yr of Program	Program Title	Program Code *	Program Provider	Number of ContactHours

\* Program Code: W= Workshop/Seminar, C= State/National Conferences, H= Homestudy/Correspondence, I= Internet, O= Other.

List additional programs on a separate sheet, if needed. Enclose with, but do not staple to application.

**TOTAL CONTACT HOURS PAGE 4;** \_\_\_\_\_

**TOTAL CONTACT HOURS PAGE 3:** \_\_\_\_\_

**GRAND TOTAL:** \_\_\_\_\_

- B** Before signing Candidate Affirmation, PRINT your name exactly as it appears on your current CORLN Certificate:

\_\_\_\_\_  
Name (PRINT)

**C CANDIDATE AFFIRMATION/AUTHORIZATION**

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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Date

\_\_\_\_\_  
Current RN License Number

\_\_\_\_\_  
State

Mail all four completed pages along with the appropriate fee to:

**CORLN Recertification  
Professional Testing Corporation  
1350 Broadway, Suite 800 Floor  
New York, NY 10018**