Activity Consultant/Educator – Board Certified AC-BC
Activity Professionals National Credentialing Center

Name: _____ Date: _____

Address: _____ Apt # _____ P.O. Box _____

City: _____ State/Prov _____ Zip _____

Home Phone _____ Cell # _____

Home/Preferred Email: _____

Employer: _____

Address: _____ P.O Box _____

City _____ State/Prov _____ Zip _____

Work Phone _____ W-Email _____

How did you hear about the Credentialing Center? _____

Currently applying for: Activity Consultant/Educator - Board Certified (AC-BC)

Path 1_____Path 2_____Path 3_____

Submit the appropriate documentation/verification required of your path as the attached forms for Education, Experience, Continuing Education, Course, and Exam where applicable.

Please Note: Application Fee is **non-refundable**. If all required documentation is not included or not received within 3 months of notification, the application will be denied.

Certification Fees

Consultant/Educator-Board Certified (AC-BC) $100

Payment Options: _____ Check _____ Certified Check _____ Money Order _____ Credit Card

Credit Card Number _____ Expiration Date_____ 3-digit code (on back) _____

Signature _____ Date _____ __

APNCC
17840 Weymouth Ave, Parker CO 80134-7775
303-317-5682 . E: office@apncc.org . http://www.apncc.org

APNCC
ACTIVITY PROFESSIONALS NATIONAL CREDENTIALING CENTER

EDUCATION

Please complete the portions of this page that apply to the Path you are following:

Path 1____ Path 2 ____ Path 3 ____

College/University	State	Dates Attended	Major	Degree Awarded
		to		
		to		
		to		

A copy of your college transcript or of diploma must also be sent with this application.

WORK EXPERIENCE

Complete the portions of this page that apply to the Path you are following. Also submit the written verification required per the Standards. Follow the path for the number of years within which employment must have occurred prior to this application. (All "other" positions must serve long-term care and be primarily an activity position) Figure 2000 hours for each full-time year (40-hour week).

Employer _____ Phone _____

Address_____ P.O. Box _____

Type of Facility:

_____ Skilled Nursing Care _____ Assisted Living _____ Retirement Community

_____ Alzheimer/Dementia _____ Adult Day _____ Other _____

Name of Supervisor _____ Title _____

Work Phone _____ Ext _____ Email _____

Employment Dates: Beginning _____ Ending _____ Full Time _____ Part Time _____

Job Title_____ Total # of hours worked for this employer _____

Employer _____ Phone _____

Address_____ P.O. Box _____

Type of Facility:

_____ Skilled Nursing Care _____ Assisted Living _____ Retirement Community

_____ Alzheimer/Dementia _____ Adult Day _____ Other _____

Name of Supervisor _____ Title _____

Work Phone _____ Ext _____ Email _____

Employment Dates: Beginning _____ Ending _____ Full Time _____ Part Time _____

Job Title_____ Total # of hours worked for this employer _____

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Employer _____ Phone _____
Address_____ P.O. Box _____

Type of Facility:

_____ Skilled Nursing Care _____ Assisted Living _____ Retirement Community

_____ Alzheimer/Dementia _____ Adult Day _____ Other _____

Name of Supervisor _____ Title _____

Work Phone _____ Ext _____ Email _____

Employment Dates: Beginning _____ Ending _____ Full Time _____ Part Time _____
Job Title_____ Total # of hours worked for this employer _____

CONTINUING EDUCATION

Submit a **copy** of written verification of all continuing education, per the Standards. **DO NOT** send original copies of certificates, they will not be returned to you. Submit the number of hours required by the Path you are following.

If you attend a conference or workshop with more than one education topic, you only need to write down the conference/workshop title and the total hours. Reviewers will verify against the certificate.

Event (Workshop, conference, in-service, etc.)	Date(s)	# CE Hours	Topic Area	Face -Face

*You may use another sheet if necessary or the reverse of this page.

APNCC COMPETENCY EXAM: Date Exam was taken _____ Pass % _____
Submit a copy of you Exam Certificate stating you passed the APN Competency Exam

Do not forget to include applicable documentation with your application:
Verification of Education
Verification of Employment on Letterhead
Copies of Certificates of Attendance for the required number of CE hours. Exam Certificate

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DISCLAIMER AND DECLARATION
This Declaration must be signed.

Confidentiality Release (optional): I agree that my email address may be used for purposes of sending APN Credentialing Center information only. Your email address will not be given or sold to any outside entity.

_____ _____
Signature Date

DECLARATIONS – APN CREDENTIALING CENTER AGREEMENT

APN Credentialing Center Agrees to process your application for certification subject to your agreement to the following terms and conditions:

1. To be bound by and in compliance with all APN Credentialing Center Paths and Standards and rules relating to eligibility, renewal and re-certification, including but not limited to, demonstration of educational, experience, continuing education and course or exam requirements, payment of any applicable fees, and compliance with all APN Credentialing Center verification and documentation requirements.
2. To authorize APN Credentialing Center to release/publish, at the sole discretion of APN, Credentialing Center any information regarding your certification or re-certification to State or Federal organizations/agencies, State or National Associations, other health-care organizations, employers or the public.
3. To hold APN Credentialing Center harmless and to waive, release and exonerate APN Credentialing Center, it's officers, committee members, employees, directors and agents from any claims that you may have against APN Credentialing Center arising out of APN Credentialing Center's review of your application or eligibility for certification, renewal, or re-instatement, or issuance of a sanction or other decision.
4. To provide information in the application that is accurate. You agree to revocation or other limitation of your certification, if granted, should any statement made/documentation provided with this document or hereafter supplied to APN Credentialing Center be found to be false or inaccurate or if you violate any of the standards, rules or regulations of APN Credentialing Center.
5. To keep APN Credentialing Center appraised of any name/contact information changes. APN Credentialing Center shall not be held responsible if not informed by applicant of said changes.
6. To keep my certification renewed every two years. APN Credentialing Center will remind me of my renewal at least 3 months in advance. However, it is my responsibility to keep up with my renewal dates and renew on time. Should said reminder not arrive it will be my responsibility to follow APN Credentialing Center requirements for late payment or reinstatement
7. To agree that by signing this document, APN Credentialing Center has the right to verify any information supplied on/with this document with the appropriate entities. I agree to hold APN Credentialing Center harmless from any results of verification checks.

_____ _____ _____
Printed name Signature Date

Thank You for Applying for APN Credentialing Center Board Certification

Revised 12/02/2020

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Consulting/Education Experience

Complete the portions of this page that apply to the Path you are following. Submit required written verifications per the Standards. Must meet Consulting Standards in 3 of the 6 categories. Refer to the Standards for consulting/educating allowances.

Path 1 (200 hours) ___ Path 2 (300 hours) ____ Path 3 (0 hours) ____

Actual Consulting:

_____

_____

_____

Dates: _____ Attach Letters of Verification

Total consulting hours: _____

_____

Author of Book, Magazine Articles:

_____

_____

_____

Dates _____ Attach Copies

Total Consulting Hours _____

_____

Education/Teaching Sessions:

_____

_____

_____

Dates _____ Attach Copies of Certificates

Total Consulting Hours _____

_____

Supervision of Staff/Interns:

_____

_____

_____

Dates _____ Attach Letters of Confirmation

Total Consulting Hours _____

Other:

_____

_____

_____

Dates _____ Attach Verification

Total Consulting Hours _____

Total Hours of Consulting/Education Experience listed above _____