APPLICATION FOR BECOMING A NURSING CENTER OF EXCELLENCE

FACILITY / APPLICANT INFORMATION

Practice Name:		
Physicians:		
Current Address:		
City:	State:	ZIP Code:
Contact E-mail:		

NURSE EMPLOYMENT OVERVIEW

How many Nurse Practitioners do you employ in your practice? _____

How many Registered Nurses do you employ in your practice? _____

DETAILED NURSING DATA: PLEASE INCLUDE NAME AND TITLE (RN, BSN, NP, ETC.), YEARS IN REPRODUCTIVE ENDOCRINOLOGY NURSING, AND YEARS WORKING IN YOUR PRACTICE (PLEASE ADD PAGES IF NEEDED)

Name:	Title:	Yrs in RE:	Yrs:
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EXAMINATION INFORMATION

Please list the Registered Nurses and Nurse Practitioners who have completed the Certificate Examination through ASRM:		

RENEWAL WILL BE REQUIRED EVERY 3 YEARS

AUTHORIZATION AND SIGNATURE

I authorize the verification of the information provided on this form. I have discussed this information with my nursing staff and have permission to share their information with ASRM. I have made a copy of this application prior to submitting.

Printed Name of applicant:	Title:
Signature of applicant:	Date:

Below For Internal Verification Only

#Eligible:	#Passed Course:	Percentage:
Approved?	Notified:	Date of Review:

* NOTE: To submit a printed version of this application, please scan and send to Katie Odom, kodom@asrm.org or fax to 205-978-5018.