Certified Hyperbaric Registered Nurse® Exam Registration Form

National Board of Diving & Hyperbaric Medical Technology
9 Richland Medical Park, Suite 440, Columbia, SC 29203 USA
Phone: (803) 434-7802 Fax: (866) 451-7231
Email: nbdhmt@aol.com
www.nbdhmt.org

You must register 60-days before your examination date

Send proof of the following requirements, along with completed registration form, to NBDHMT headquarters.

- Current valid Registered Nurse license for the state in which you practice;
- Minimum of two years clinical experience in an in hospital or hospital based clinic setting or one year critical care experience as a registered nurse.
- Successful completion of an entry level NBDHMT approved Hyperbaric Medicine training course within five years of this application. If course attendance is greater than five years, applicant must show proof of 60 Category "A" (hyperbaric related) CEU's . (Nursing school transcripts do not qualify for initial certification)
- *Minimum of one-year active hyperbaric medicine experience within the last two years, which includes 480 hours of direct hyperbaric patient care performed, recorded and signed by a CHRN acting as your preceptor; meaning you are not directly working with another CHRN.*
- *Please review BNACB Preceptorship Objectives on the Hyperbaric Nurse section of website.*

Please reference Resource Manual for additional guidelines

Test Location – Please contact a local Community College or University to verify testing date/time

Location: Date/Time:

Name as it appears on your government issued I.D.

Last Name: _____ **First Name:** _____

Home Address: _____

City: _____ **State/Province:** _____ **Zip (Postal) Code:** _____

Country: _____ **Work Phone:** _____

Home Phone: _____ **Mobile Phone:** _____

Email: _____ **Work Fax:** _____

State Board of Nursing License #: _____

Hyperbaric Medicine Course Attended : _____ **Year:** _____

Address: _____

City: _____ **State/Province:** _____ **Postal Code:** _____

Present Institutional Affiliation: _____

Registration Fee

*BNA Member ($250.00 USD): _____

*UHMS or *ACHM Member ($300.00 USD): _____

Non Member of organizations listed above($400.00): _____

Total: _____

**Evidence of membership required*

Supporting documents must be submitted with all applications, including Experience logs signed off by a CHRN preceptor. Please let the National Board know if a preceptor is not available to you.

Payment: ○ **Check or Money Order payable to NBDHMT** **Credit Card:** ○ **Visa** ○ **Mastercard**

Card Number: _____ **Expiration Date:** _____ **Postal Code:** _____ **CVC:** _____

For Office Use Only: Date Received: _____ ☐ Payment Enclosed ☐ Payment Cleared ☐ Data

CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of **National Board of Diving & Hyperbaric Medical Technology (NBDHMT)** may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with **NBDHMT's** consideration of my certification and recertification through **NBDHMT**, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.

III. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

IV. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

V. I understand that if I am a resident of **Minnesota/Oklahoma (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box. ☐

NOTE: A felony conviction will disqualify the applicant for a minimum of five (5) years from completion of sentence.

Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

CANDIDATE COMPLETE THE FOLLOWING:

_____ _____
Signature Today's Date

_____
Please print full name

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

_____ _____
Month, Day and Year of Birth Social Security Number

_____ _____
Home Address City State Zip

_____
Name as it appears on License City State

Have you ever been convicted of a crime? __ No __ Yes If yes, please provide city and state of conviction and details of conviction.

_____

_____

FAIR CREDIT REPORTING ACT NOTICE:
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state. Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by (INSERT COMPANY NAME) by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

◯ I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.