

# Certified Hyperbaric Registered Nurse® Recertification Form

National Board of Diving & Hyperbaric Medical Technology 9  
P O Box 758 Pelion, SC 29123 USA Phone: (888) 312-2770  
Fax: (866) 451-7231  
Email: nbdhmt@aol.com  
www.nbdhmt.org

Date of Application: \_\_\_\_\_ CHRN Number: \_\_\_\_\_ Date of Initial Certification: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name as it appears on your government issued I.D.

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Recertification - Certified Hyperbaric Registered Nurse® attach written verification of:

- CHRN Admin: See Nursing Resource Guide
- Current valid Registered Nurse license in the state where you practice.
- Letter of recommendation from the Manager/Medical Director including validation of hyperbaric experience (minimum of 1 year hyperbaric experience with a minimum of 480 hyperbaric hours in the last 12 months).
- Proof of a minimum of (40) CEUs (total) within the past 4 years. A minimum of (20) CEUs MUST be Category "A" in hyperbaric oxygen therapy field.

RNs who currently have their CHRN® may apply for advances (ACHRN® or CHRNC®). In addition to the requirements of recertification (CHRN®) listed above, the following criteria must be met to achieve advanced certification and to maintain that level of achievement.

## ACHRN® Certification - Advanced Certified Hyperbaric Registered Nurse® attach written verification of:

- CHRN Admin: See Nursing Resource Guide
- Proof of a minimum of 60 CEUs (total) within the past 4 years. A minimum of 30 CEUs MUST be Category "A" in hyperbaric oxygen therapy field.
- Minimum of 3 years experience in the field of hyperbaric medicine.

Provide written verification of **at least 2** of the following:

- Contributes to the administrative activities of the Hyperbaric Unit/Department (per Manager/Supervisor).
- Teaches classes or presents lectures on hyperbaric medicine.
- Provides primary responsibility for planning/coordinating nursing care for patients undergoing hyperbaric oxygen therapy.
- Active participant in the Baromedical Nurses Association and/or Undersea and Hyperbaric Medical Society as an officer or committee member.

## CHRNC® Certification - Certified Hyperbaric Registered Nurse Clinician® attach written verification of:

- CHRN Admin: See Nursing Resource Guide
- Master's Degree in Nursing or a Master's Degree in health related area from an accredited academic program.
- Proof of a minimum of 60 CEUs (total) within the past 4 years. A minimum of 30 CEUs MUST be Category "A" in hyperbaric oxygen therapy field.
- Minimum of 5 years experience in the field of hyperbaric medicine.

Provide written verification of **at least 3** of the following:

- Responsible for administrative activities and nursing care activities of the Hyperbaric Unit/Department.
- Speaker at national/regional hyperbaric conferences and workshops.
- Contributes to the production of hyperbaric materials for national/regional distribution, i.e. journal articles, manuals, videos, etc.
- Active participant in the Baromedical Nurses Association and/or Undersea and Hyperbaric Medical Society as an officer or committee member.
- Principle investigator or co-investigator in published hyperbaric or related research.

## Recertification Fees

BNA Member (\$150.00 USD): \_\_\_\_\_

UHMS or ACHM Member (\$200.00 USD): \_\_\_\_\_

Non-Member of BNA, UHMS, OR ACHM (\$250.00 USD): \_\_\_\_\_

Additional, Reinstatement to Active Status (\$100.00): \_\_\_\_\_

**Total Due:** \_\_\_\_\_

Recertification is required every four years and should be received by the National Board of Diving and Hyperbaric Medical Technology before expiration date. If CHRN® certification is lapsed, recertification may be obtained by submitting the recertification requirements above and lapse will also incur a restatement fee of \$100.00 USD added to recertification fees listed to the left. No member discounts will be applied.

Please see Resource manual for more information.

## Payment

- Check or Money Order payable to NBDHMT     Credit Card     Visa     Mastercard

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ CVC: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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; or criminal/ civil/driving record history. I understand that General Information Services, Inc., on behalf of **National Board of Diving and 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 .

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

## CANDIDATE TO 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

Have you ever been convicted of a crime?  Yes  No 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 is 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 NBDHMT 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.