



CERTIFIED FORENSIC NURSE, CFN® PROGRAM APPLICATION FOR CERTIFICATION EXAMINATION

2750 East Sunshine • Springfield, MO 65804

Phone (800) 423-9737 • Fax (417) 881-4702 • www.ACFEI.com

Please submit the following documentation along with this completed application: • Professional Resume • Copy of your current RN license • Degree(s) if applicable • Signed Clinical Validation Form • Verification of Completed Forensic Nursing Educational Program(s)

PERSONAL INFORMATION

Prefix _____ First Name _____ M.I. _____ Last Name _____ DOB _____
Address _____ City _____ State _____ ZIP _____
Work Number _____ Home Number _____ Fax Number _____
E-Mail _____ Designation _____

PROFESSIONAL INFORMATION

Registered Nurse (RN) License #: _____ State of Licensure: _____ Expiration Date: _____

of years practicing as a registered nurse: _____ # of years practicing as a forensic nurse: _____

Please provide two professional references in the space provided below.

Reference #1 Name _____ Company or organization _____
Title _____ Phone number _____

Reference #2 Name _____ Company or organization _____
Title _____ Phone number _____

MEMBERSHIP CATEGORIES AND FEE INFORMATION

Please select the appropriate membership category, fees, and method of payment. You must be a member of ACFEI to be eligible to earn the CFN designation. If you are not currently an ACFEI member, please choose one of the categories of membership listed below. If you are an ACFEI member, please provide your member identification number below.

Section A: ACFEI Membership Categories:

Payment is processed upon receipt of application. If application is denied or cancelled, a \$50 administrative fee will be assessed and the remaining amount will be refunded. (International mailing addresses, please add \$25 to annual dues to cover additional postage.)

- Member: \$165** for 1 year's annual dues
- Life Member: \$2500** lifetime membership fee (Never pay dues again. Payment plans are available, please call for details.)
- Current Member:** Member Identification Number: _____ \$ _____

Section B:

- Certified Forensic Nurse, CFN, Online Examination, \$495** \$ _____

Total Amount Due: \$ _____

Section C: Payment Information

Payment must accompany application. You may choose the payment method that is most convenient (personal/company check or credit card).

- MasterCard Visa American Express Check Money Order Make checks payable to ACFEI

Card Number _____ Expiration Date: _____ Signature _____

POLICY ON DENIAL, SUSPENSION, OR REVOCATION OF CERTIFICATION

Any of the following actions taken by the applicant will result in the denial, suspension, or revocation of Certified Forensic Nurse credentials: 1.) Falsification of the application; 2.) Falsification of any material and/or information requested by ACFEI; 3.) Any restrictions, such as revocation, suspension, probation, or other sanctions of professional nursing license by a nursing authority; 4.) Misrepresentation of CFN status by the designation holder, and 5.) Cheating on the CFN examination by the applicant.

STATEMENT OF UNDERSTANDING AND AGREEMENT

I hereby attest that I have read and understand the American Board of Forensic Nursing's policy on Denial, Suspension, or Revocation of Certification and that its terms shall be binding on all applicants for certification and all Certified Forensic Nurses for the duration of their certification. I hereby apply for certification offered by the American Board of Forensic Nursing. I understand that certification depends upon successful completion of the specified requirements. I further understand that the information accrued in the certification process may be used for statistical purposes and for evaluation of the certification program. I further understand that the information from my certification records shall be held in confidence and shall not be used for any other purpose without my permission. To the best of my knowledge, the information contained in this application is true, complete, correct, and is made in good faith. I may be asked to provide additional documentation. If I misrepresent my credentials, refuse to provide documentation at a later time if asked, or allow my membership with the American College of Forensic Examiners Institute to lapse, I understand and agree that my CFN status will be revoked and my membership terminated. I affirm that all of the information that I have proved to ACFEI is true, correct and complete, and I agree to hold harmless and indemnify ACFEI and its officers, directors, employees and agents for any misrepresentation of my credentials and for all claims, loss, judgment or expense. I understand that ACFEI reserves the right to verify any and all information on this application. I certify that I have not been convicted of a felony. I have not been disciplined for an ethical violation in the last 10 years, nor am I under investigation by any legal or licensing board. ACFEI does not endorse, guarantee or warrant the work or opinions of any individual members. Membership does not imply licensing or registration by the organization of a member's qualifications, abilities or expertise. The objective of ACFEI's publications and the activities that it sponsors are for informative and educational purposes. The views expressed by the authors, publishers or presenters are their own views and do not necessarily reflect those of ACFEI. ACFEI does not assume any responsibility or liability for its members or subscribers' efforts to apply or utilize the information, suggestions, or recommendations made by the organization, publication resources, or activities.

SIGNATURE : _____ **DATE:** _____



CERTIFIED FORENSIC NURSE, CFN[®], PROGRAM CLINICAL EXPERIENCE VALIDATION FORM

This form must be signed and dated by a current supervisor, preceptor, or peer/colleague that can validate your relevant clinical experience related to forensic nursing. Please submit this form with your CFN application.

As a current supervisor, preceptor, or peer/colleague of the Certified Forensic Nurse, CFN, program applicant

_____, I verify that the candidate has satisfactorily
(Insert Applicant's Name)
completed didactic educational coursework in forensic nursing, including both classroom instruction and supervised clinical experience.

Signature: _____ Date: _____

Name of signing supervisor, preceptor, or peer/colleague (please print):

Company or organization: _____ Title: _____

Address _____

City _____ State _____ ZIP _____

Telephone Number _____ Fax Number _____

Please indicate your professional relationship with the CFN applicant:

- Supervisor
- Preceptor
- Peer/Colleague

Please return completed validation form to:
American College of Forensic Examiners Institute
2750 East Sunshine Street
Springfield, MO 65804
Phone (800) 423-9737 or (417) 881-3818
Fax (417) 881-4702
www.ACFEI.com