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Certification of Competency in Cardiac Rhythm Device Therapy for the **Allied Professional**

Examination Application

Exam Date: September 22, 2010
Registration Opens: February 23, 2010

Early Registration Deadline: April 12, 2010
Final Registration Deadline: May 18, 2010

PART I. PERSONAL INFORMATION

(Please provide your legal name as it appears on your government-issued photo ID)

Customer ID # (if available): _____ Prefix: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Suffix: _____ Degree(s): _____

Business Address Check here if you prefer to be contacted at this address.

Business Name: _____

Title: _____

Department: _____

Address 1: _____

Address 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Business Phone: _____ Business Fax: _____

Business E-mail: _____ Check here if you prefer to be contacted at this e-mail address.

Home Address Check here if you prefer to be contacted at this address.

Address 1: _____

Address 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Home Phone: _____ Home Fax: _____

Home E-mail: _____ Check here if you prefer to be contacted at this e-mail address.

Do you plan to take the exam in your country of residence? ___ Yes ___ No If not, in which country? _____

Demographics

What is your gender?

- Male Female Choose not to reply

What is your Date of Birth?

____ / ____
Month Year

What is your language fluency? (Indicate accordingly: S = Speak, R = Read, B = Both)

- Cantonese English French German
 Hebrew Italian Japanese Mandarin
 Spanish Other: _____

What is your primary occupation? (Check one)

- Engineer Physician Assistant
 Nurse/Practitioner Manager/Administrator
 Scientist Educator
 Sales/Marketing/Product Develop. Technician/Technologist

What is your secondary occupation? (Check all that apply)

- Engineer Physician Assistant
 Nurse/Practitioner Manager/Administrator
 Scientist Educator
 Sales/Marketing/Product Develop. Technician/Technologist

What is your primary specialty/ practice area? (Check one)

- Basic Research Science Heart Failure
 Translational Research Science Interventional Cardiology
 Clinical Research Science Pediatric Cardiology
 Pediatric EP Clinical Electrophysiology
 Surgery Clinical Cardiology
 Hypertrophic Cardiomyopathy Other _____

What is your secondary specialty/ practice area? (Check one)

- Basic Research Science Heart Failure
 Translational Research Science Interventional Cardiology
 Clinical Research Science Pediatric Cardiology
 Pediatric EP Clinical Electrophysiology
 Surgery Clinical Cardiology
 Hypertrophic Cardiomyopathy Other _____

How do you spend the majority of your time? (Check one)

- EP lab Research
 Device Lab Inpatient Care
 Outpatient Care

How many procedures do you perform annually? (Check all that apply)

- Administration Yes No
 Patient Follow-up Visits/Evaluation and Management Yes No
- | | None | 1-25 | 26-50 | 51-100 | 101-200 | 200+ |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Device Interrogation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Device Implantations: ICDs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Device Implantations: CRT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Device Implantations: Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> VT Ablation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> AF Ablation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> SVT Ablation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lead Extractions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you manage patients with: (Check all that apply)

- Atrial Fibrillation
 Heart Failure
 Risk for Sudden Cardiac Arrest

What is your primary work environment? (Check all that apply)

- Academic Institution Hospital (Non-Academic)
 EP Private Practice Industry
 Multi Discipline Cardiology Private Practice Veterans Administration
 Health Maintenance Organization/ Association
Preferred Provider Organization Other: _____

How many years are you out of training? (Check one)

- In Training 11-20
 1-5 21+
 6-10

How did you find out about the CEPS exam?

(Check all that apply)

- CLD: *Cath-Lab Digest*
 CLO: Cath-Lab Online
 ELD: *EP-Lab Digest*
 ELO: EP-Lab Online
 HRE: Heart Rhythm Society E-mail
 HRJ: *HeartRhythm* Journal
 HRO: Heart Rhythm Society Online
 IBE: IBHRE E-mail
 IBO: IBHRE Online
 JCE: *Journal of Cardiovascular Electrophysiology*
 JICE: *Journal of Interventional Cardiac Electrophysiology*
 PACE: *Pacing and Cardiac Electrophysiology*

What other professional societies do you belong to?

(Check all that apply)

- American Association of Heart Failure Nurses (AAHFN)
 Italian Society of Pacing and Arrhythmology (AIAC)
 Chinese Heart Rhythm Society (CHRS)
 Chinese Society of Pacing and EP (CSPE)
 Japanese Heart Rhythm Society (JHRS)
 American Association for Thoracic Surgery (AATS)
 American College of Cardiology (ACC)
 American College of Physicians (ACP)
 American Heart Association (AHA)
 American Medical Association (AMA)
 American Society of Echocardiography (ASE)
 American Society of Nuclear Cardiology (ASNC)
 Cardiac Electrophysiology Society (CES)
 European Society of Cardiology (ESC)
 European Heart Rhythm Association (EHRA)
 Heart Failure Society of America (HFSA)
 International Cardiac Pacing and Electrophysiology Society (ICPES)
 National Cardiac Society (NCS)
 Pediatric and Congenital Electrophysiology Society (PACES)
 Royal College of Physicians (RCP)
 Society of Thoracic Surgeons (STS)
 Other _____

Are you an NIH grant recipient?

- Yes No

Are you a current member of the Heart Rhythm Society?

- Yes No

PART II. EXAM ELIGIBILITY

In order to be approved to take the Certification Exam in Cardiac Rhythm Device Therapy, Allied Professionals must verify that they are currently working or have worked within the past two years in the field of Cardiac Pacing, Electrophysiology or Cardioversion Defibrillation upon submitting their application. All candidates must attach a minimum of one letter of professional reference from a colleague, immediate supervisor or Human Resources representative from the candidate's place of employment. Applications received without letters of reference will not be approved for examination.

I attest that I am currently involved in the areas of Cardiac Pacing, Electrophysiology or Cardioversion Defibrillation or have been involved within the past two years. Attached to this application is a letter of reference from a colleague or supervisor. I am aware that this reference is verification only of my involvement in the field and that my exam eligibility does not depend upon my current employment.

Are you taking this examination for: *(Check one)*

- First Time
- Re-examination
- Recertification

If you are recertifying, when did you last pass the exam?

(mm/dd/yyyy) _____

PART III. EDUCATION & TRAINING

Undergraduate

Major/Degree: _____ City: _____
School/Institution/Agency: _____ State/Province: _____
Degree/Certificate Earned: _____ Country: _____
Graduation Month: _____ Graduation Year: _____

Graduate

Major/Degree: _____ City: _____
School: _____ State/Province: _____
Degree/Certificate Earned: _____ Country: _____
Graduation Month: _____ Graduation Year: _____

Post-Graduate/Doctoral

Major/Degree: _____ City: _____
School: _____ State/Province: _____
Degree/Certificate Earned: _____ Country: _____
Graduation Month: _____ Graduation Year: _____

Training

Major/Degree: _____ City: _____
School/Institution/Agency: _____ State/Province: _____
Degree/Certificate Earned: _____ Country: _____
Graduation Month: _____ Graduation Year: _____

Additional Training

Major/Degree: _____ City: _____
School/Institution/Agency: _____ State/Province: _____
Degree/Certificate Earned: _____ Country: _____
Graduation Month: _____ Graduation Year: _____

PART IV. BOARD CERTIFICATIONS/ELIGIBILITIES

I am currently certified/eligible in the following fields:

<input type="checkbox"/> Registered Nurse	Exp. Mo./Yr. _____	<input type="checkbox"/> Critical Care Registered Nurse	Exp. Mo./Yr. _____
<input type="checkbox"/> Pediatric Nurse	Exp. Mo./Yr. _____	<input type="checkbox"/> Advanced Practice Nurse	Exp. Mo./Yr. _____
<input type="checkbox"/> Nurse Practitioner	Exp. Mo./Yr. _____	<input type="checkbox"/> Acute Clinical Care Specialist	Exp. Mo./Yr. _____
<input type="checkbox"/> Certified Cardiovascular Technician	Exp. Mo./Yr. _____	<input type="checkbox"/> Other: _____	Exp. Mo./Yr. _____

PART V. CLINICAL EXPERIENCE/TRAINING

How many years of experience do you have in the fields of Cardiac Pacing/Electrophysiology since completing your training?

(Check one box)

- None
 1 to 2 years
 3 to 5 years
 6 to 10 years
 11 to 19 years
 20 years or more

How many months have you devoted to specific training in Electrophysiology, Cardiac Pacing and Cardioversion Defibrillation in the clinical settings listed below? *(Check one box per question)*

ACUTE CARE UNITS

- None 1 to 6 months 7 to 12 months
 13 to 24 months More than 24 months

CARDIAC DIAGNOSTICS, PACEMAKER CLINIC

- None 1 to 6 months 7 to 12 months
 13 to 24 months More than 24 months

ELECTROPHYSIOLOGY LABORATORIES

- None 1 to 6 months 7 to 12 months
 13 to 24 months More than 24 months

OTHER *(Please Describe)* _____

- None 1 to 6 months 7 to 12 months
 13 to 24 months More than 24 months

PART VI. PRESENT INVOLVEMENT

How many patient cases do you participate/assist with annually?

(Check one box per question)

	None	1-25	26-50	51-100	101-200	200+
1. Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Pacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. EP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. ICD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you participate/assist with implanting permanent pacemakers? If so, how many?

- None 1 to 25/year 26 to 50/year
 51-100/year 101 to 200/year 200+/year

Do you follow up with patients with permanent pacemakers? If so, how many?

- None 1 to 25/year 26 to 50/year
 51-100/year 101 to 200/year 200+/year

Do you participate/assist with performing cardiac electrophysiology studies? If so, how many?

- None 1 to 25/year 26 to 50/year
 51-100/year 101 to 200/year 200+/year

Do you participate/assist with implantation of ICDs? If so, how many?

- None 1 to 25/year 26 to 50/year
 51-100/year 101 to 200/year 200+/year

Do you follow up with patients with ICDs? If so, how many?

- None 1 to 25/year 26 to 50/year
 51-100/year 101 to 200/year 200+/year

What percentage of your responsibilities is devoted to Electrophysiology, Cardiac Pacing and Cardioversion Defibrillation?

	None	1-30%	31-60%	61-75%	75+%
1. Pacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Electrophysiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. ICD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART VII. PAYMENT OF FEES

Exam Fees

Member Early Fee: **\$795.00**

Non-member Early Fee: **\$945.00**

Member Standard Fee: **\$895.00**

Non-member Standard Fee: **\$995.00**

Early registration ends at midnight on April 13, 2010. Final registration ends at midnight on May 19, 2010. Member fees apply only to Heart Rhythm Society members whose member statuses are current the day their exam application is submitted. Refunds will not be given to anyone whose membership is processed following the date of exam registration.

Refund & Cancellation Policy

Cancellation requests must be submitted in writing by the exam candidate to IBHRE prior to the exam date. A \$75.00 processing fee will be withheld for all cancellation requests, in addition to the cancellation fees listed below. Telephone requests will not be honored.

Cancellations will be processed if a request is received at the IBHRE office in writing:

- 6 weeks prior to the exam date – fees will be refunded less \$300.00
- 4 weeks prior to the exam date – fees will be refunded less \$500.00
- 2 weeks prior to the exam date and “No Shows” on exam date – NO refund

Refunds will only be issued upon cancellation of exam registration. Requests from third parties to cancel or transfer a candidate’s registration will not be honored. Third parties who submit payment on behalf of an exam candidate should be aware that they do so voluntarily, at their own risk, and will not be recognized as party to the agreement made between the exam candidate and IBHRE through submission of this application. All refunds will be issued directly to the party initially responsible for remitting payment. All exam registrations are non-transferable.

Applicants who do not meet eligibility requirements for the exam will be refunded the full amount less a \$75 processing fee.

Payment Information

Check enclosed (Payable to IBHRE) Check Number: _____

Credit Card VISA MasterCard AMEX

Card Number: _____ Exp. Date: _____

Cardholder Name: _____

Cardholder Signature: _____

Fees must be submitted with the completed application. Early and standard fees are shown above. Deadlines will be strictly enforced. All checks must be drawn from a US bank in US dollars. Credit card payment is available (VISA, MASTERCARD, and AMERICAN EXPRESS ONLY).

Payment Contact Information

Please complete the below portion with information of whom we should contact regarding any payment concerns/questions.

Name: _____
First, Middle, Last (Surname)

Address : _____

City: _____ State/Prov: _____

Zip: _____ Country: _____

Phone: _____ Fax: _____
Country/Area Code - Number Country/Area Code - Number

E-mail: _____

PART VIII. VALIDATION OF APPLICATION

Exam Candidate Responsibilities

By submitting this application:

I attest that I have read in full the *IBHRE® Certification Candidate Bulletin for the Physician and Allied Professional* and am aware of my rights and responsibilities as a certification examination candidate and the policies of IBHRE.

I acknowledge that submission of this application does not guarantee approval to take the exam and that final approval is dependant upon my ability to meet the eligibility requirements described herein and in the *Certification Candidate Bulletin*. I hereby authorize IBHRE to conduct an independent verification of any licenses, credentials or employment status indicated this application.

I am aware that upon official approval I will be issued an Exam Scheduling Permit and instructions explaining the process for securing a test location nearest to me.

I acknowledge that I will be responsible for securing my testing location. I further acknowledge that I am not guaranteed a testing location to be within immediate proximity to my home or work, neither am I guaranteed my preferred testing location to be available on the date of the exam. I am aware that I may seek the assistance of IBHRE in scheduling an exam site by contacting the IBHRE administrative office.

I attest that I have read and understand the IBHRE cancellation and refund policy and accept that failure to show for my exam sitting without requesting cancellation within the prescribed timeframes will result in the forfeiture of my exam fees.

I guarantee that the information I have provided in this application is current, accurate and true to the best of my knowledge. I am aware that the information provided in this application is used to disseminate information to me regarding scheduling procedures and score results. Furthermore I am aware that information I have provided will be used to develop relevant statistical data for the purpose of evaluating mine and others' exams. I am aware that any statements or claims regarding my eligibility, education or professional experience found to be false or misrepresented may result in the termination of my exam eligibility or the revocation of my IBHRE certification.

IBHRE Code of Ethics

I. IBHRE Code of Ethics

The International Board of Heart Rhythm Examiners holds all of its certificants and volunteer leaders working in the field of cardiac pacing and cardiac electrophysiology to the following responsibilities:

- A. Uphold the values, ethics, and mission of the profession and IBHRE
- B. Conduct all personal and professional activities with honesty, integrity, respect, fairness, good faith and competence in a manner that will reflect well on the profession and IBHRE
- C. Comply with all laws and regulations of the jurisdictions in which the professional conducts his/her activities
- D. Maintain competence and proficiency in their profession by undertaking a personal program of assessment and continuing professional education
- E. Respect professional confidences and comply with all laws pertaining to patient confidentiality and disclosure
- F. Enhance the dignity and image of the profession and IBHRE through positive personal actions
- G. Be truthful, candid and compassionate in all professional communications with patients and others in the practice of cardiac pacing and electrophysiology and avoid information that is false, misleading, inflammatory, and deceptive, or information that would create unreasonable expectations

IBHRE endorses and hereby incorporates by reference the Code of Ethics of the Heart Rhythm Society, as relevant to certificants and volunteer leaders in their work for IBHRE and in their practices and activities in the fields of pacing and electrophysiology. The Code of Ethics of the Heart Rhythm Society can be found at www.HRSonline.org.

II. Ethical Behavior of Volunteer Leaders & Staff

IBHRE holds all of its stakeholders, most particularly volunteers, staff, contractors and other agents representing IBHRE to the following responsibilities:

- A. Act only within the scope of authority as specified in the bylaws and written policies of IBHRE;
- B. Make only commitments that an individual is authorized to make or that IBHRE can make without violating established practices and policies;
- C. Avoid the exploitation of professional relationships or positions in the organization, whether elected or appointed, for personal gain;
- D. Respect professional confidences and protect the confidentiality of IBHRE information, including intellectual property, candidate identities, score results information, personnel information, and other information as articulated in the IBHRE Confidentiality Policy;
- E. Refrain from using association with IBHRE to promote or endorse external products or services; and
- F. Accept no gifts or benefits offered with the expectation of influencing a decision when conducting business on behalf of the organization.

III. Cause for Sanctions from IBHRE

IBHRE may issue sanctions in the event an exam candidate or certificant:

- A. Is found to have falsified or misrepresented any personal or demographic information provided on an exam application or otherwise requested by IBHRE;
- B. Misrepresents or misuses an IBHRE credential;
- C. Is found and proven guilty of cheating on an IBHRE certification examination;
- D. Is found and proven guilty of assisting others to cheat on a certification examination;
- E. Is found in possession of IBHRE examinations, test items or any other confidential and proprietary materials without direct authorization from IBHRE;
- F. Is convicted of a crime, or has undergone limitation, sanctions, revocation, or suspension by a professional health care organization, licensing board or any other private or governmental body related to cardiac care or public health safety; or
- G. Is found guilty of gross or repeated negligence or malpractice in professional practice by a medical review board or court of law.

IV. Sanctions

IBHRE may issue sanctions that include, but are not limited to:

- A. Present and/or future denial of initial certification or recertification
- B. Revocation of current certification credential(s) with the requirement to discontinue use of all claims to certification and return of any certificates issued by IBHRE.
- C. Legal action in the event the individual fails to comply with sanctions exercised by IBHRE or has perpetrated financial or other legally defensible damages against the organization.

V. Agreement to Confidentiality

By submitting (or having submitted) an application to take an IBHRE certification examination, exam candidates and certificants agree that they shall not disclose confidential information (whether oral or written in any form of media) related to, provided by or discussed during the examination or any other information identified as confidential. Exam candidates acknowledge that test questions appearing on the examination are the confidential information and copyrighted proprietary property of IBHRE, and are not to be copied, reproduced or disclosed to others.

IBHRE certificants and exam candidates should further understand that the signature provided on the exam application constitutes binding acceptance of these conditions.

Failure to comply with this confidentiality agreement may result in sanctions as articulated under Section III of this Code of Ethics and determined to be appropriate by an official review panel appointed by the IBHRE Board of Directors.

Confidentiality

By applying to take this examination, I give permission to IBHRE to use all information herein to develop relevant statistical data without individual identification and while holding this application in full and complete confidence.

Disclosure of Certification

I acknowledge that those who successfully complete an IBHRE examination are listed on the IBHRE Web Site, by name and exam year only, as an IBHRE Certified Cardiac Device Specialist. By submitting this application, I authorize IBHRE to add my name and exam year to the website provided (and only if) I receive a passing score. I further authorize IBHRE to respond to verification requests from third parties regarding the status of my certification by providing a yes/no response to my current status, date of initial certification, and expiration date. All other data and information regarding exam scores and performance must be kept fully confidential from third parties unless I provide expressed permission to IBHRE to disclose said information.

Use of Licensed Marks

I acknowledge that if, and only if, I become certified by IBHRE, I will have limited fair use of certain licensed marks as they pertain to my credential. By submitting this application I attest that I will not violate any of the trademark usage guidelines as described in the IBHRE *Licensed Marks Guidelines* regardless of the outcome of my examination. I acknowledge that the penalty for misuse of a licensed mark may result in sanctions from IBHRE.

SIGNATURE

By providing my signature below, I hereby give my consent to IBHRE to process the information provided in this application for the purpose of considering and potentially accepting me as a candidate for the "Certification Examination for Competency in Cardiac Rhythm Device Therapy for the Allied Professional." I have read and agree to abide by all policies and procedures communicated to me through this application and the *Certification Candidate Bulletin for the Physician and Allied Professional*. Furthermore, I hereby validate the statements listed above under Part VI of this application and accept the responsibilities that I will be held to as certification candidate and, upon passing this examination, an IBHRE certificant.

Applicant Signature: _____ Printed Name: _____

Date: _____

mm/dd/yyyy

The International Board of Heart Rhythm Examiners does not condone discrimination with regard to race, color, national origin, religion, sex, sexual orientation, age, disability, or veteran status in employment nor in the certification programs that it operates. The International Board of Heart Rhythm Examiners seeks to make all programs and services, including electronic and information technology, accessible to people with disabilities. In this spirit, and in accordance with the provisions of Sections 504 and 508 of the Americans with Disabilities Act, the Board provides medical professionals with reasonable accommodations to ensure equal access to programs and activities of the Board.