

# CLINICAL NUTRITION CERTIFICATION BOARD



## CERTIFIED CLINICAL NUTRITIONIST (CCN)

### EXAMINATION APPLICATION

The Clinical Nutrition Certification Board does not discriminate against any individual on the basis of religion, sex, ethnic background or physical disability.

#### CCN EXAM STUDY MATERIALS

“CCN Study Guide” \* “CCN Professional Practice Guidelines”

All Completed Forms and Credentials are Mailed to:

**CNCB Credentials Office**

15280 Addison Road, Suite 130

Addison, TX 75001

(972) 250-2829 TEL \* (972) 250-0233 FAX

#### **NO LATER THAN 30 DAYS PRIOR TO TEST DATE:**

**Two copies** of the following information should be on file at the CNCB Credentials Office thirty days prior to the selected exam. Check “CCN Credentials Check List” for complete listing.

- \* Applicant Letter requesting professional Credentials Review
- \* Completed Credentials Review Form plus \$75.00 non-refundable credentials processing fee
- \* Two Official Transcripts and diplomas from each graduating college or university
- \* Personal and Professional References Letter
- \* Completed and notarized CCN Examination Application
- \* Curriculum Vitae
- \* Examination Fee: \$450.00 Check made out to “Clinical Nutrition Certification Board” or by Mastercard or Visa along with the CCN Exam Schedule Form.

CERTIFICATION WILL NOT BE AWARDED TO ANY PERSON WHO IS UNDER INVESTIGATION IN ANY JURISDICTION FOR AN OFFENSE WHICH WOULD CONSTITUTE A VIOLATION OF THE CODE OF PROFESSIONAL RESPONSIBILITY FOR CLINICAL NUTRITIONISTS UNTIL SUCH TIME AS THAT INVESTIGATION IS DISMISSED OR OTHERWISE TERMINATED.

# APPLICATION

**BEFORE COMPLETING THIS APPLICATION, YOU MUST READ THE CODE OF PROFESSIONAL RESPONSIBILITY (The CCN Study Guide).**

I hereby certify that I have carefully and thoughtfully read The Code of Professional Ethics and Responsibility and agree to abide by and be bound by its provisions.

\_\_\_\_\_  
Signature of Applicant

NAME: \_\_\_\_\_  
                    LAST                                    FIRST                                    MI                                    MAIDEN

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE: (    ) \_\_\_\_\_ WORK PHONE: (    ) \_\_\_\_\_

FAX: (    ) \_\_\_\_\_ MOBILE: (    ) \_\_\_\_\_

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

DESIRED TEST DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ TEST CENTER: \_\_\_\_\_

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1. Are you practicing nutrition? \_\_\_\_ Yes \_\_\_\_ No
  2. Full Time? \_\_\_\_ Yes \_\_\_\_ No
  3. Part Time? \_\_\_\_ Yes \_\_\_\_ No
  4. Number of years practicing: \_\_\_\_\_
  5. Have you previously taken the CCN Certification Exam? \_\_\_\_ Yes \_\_\_\_ No  
If Yes, give location \_\_\_\_\_ and date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
  6. Do you have a Bachelor Degree in Nutrition? \_\_\_\_ Yes \_\_\_\_ No
  7. Do you have a Bachelor Degree in a related field? \_\_\_\_ Yes \_\_\_\_ No
  8. Do you understand that if your degree is in a related field, there is an academic requirement of approximately 35 hours of Science and Nutrition, plus a 900 hour Clinical internship program to complete before sitting for the exam? \_\_\_\_ Yes \_\_\_\_ No
  9. Have you ever been convicted of a felony or misdemeanor (other than a minor traffic violation)?  
\_\_\_\_ Yes \_\_\_\_ No
  10. Have you ever been found by any court, administrative or disciplinary proceeding to have committed negligence, malpractice, recklessness, wilful or intentional conduct resulting in injury to another?  
\_\_\_\_ Yes \_\_\_\_ No If Yes, please explain.
  11. Are you now or have you ever been impaired by the use of alcohol, drugs, or any intoxicant or any other physical or mental cause to a degree which interferes with your ability to perform competent and objective professional work?  
\_\_\_\_ Yes \_\_\_\_ No If Yes, please explain.
  12. Have you ever been suspended or expelled from an academic institution? \_\_\_\_ Yes \_\_\_\_ No  
If Yes, please explain.
  13. Have you completed ALL requirements, as stated by The Clinical Nutrition Certification Board to be eligible for candidacy and sit for the CCN Examination? \_\_\_\_ Yes \_\_\_\_ No If No, please explain.

Please complete the following information for all colleges and universities attended:

Name of Institution	Dates Attended	Degree	Degree Date
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

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**AFFIRMATION**

I understand that if I am granted certification and do not satisfy The CNCB/CCN Continuing Education Requirements in the stated period of time, my certification status could be suspended and/or revoked.

By signing and submitting this application, I accept the conditions set forth on The CNCB “CCN Study Guide” booklet concerning the administration of the test, the reporting of the test scores, and the certification process and policies. I certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is made good faith. I further understand that if any information is later determined to be false, The CNCB reserves the right to revoke any certification that has been granted on the basis thereof. If I send my application to the wrong testing service or do not complete the application properly, resulting in a delay, I will not hold the testing service of The CNCB liable.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**TOTAL FEE OF \$450.00 MUST BE RECEIVED NO LESS THAN 30 DAYS PRIOR TO TESTING DATE.**

**PAYMENT SHOULD MADE ON THE CCN EXAM SCHEDULE FORM.**

Enclose Check (payable to Clinical Nutrition Certification Board). or Credit Card (MasterCard or Visa) accepted. Payments are not deductible as charitable contributions for Federal Income Tax purposes. Payments may be deductible as a business expense. If in doubt, consult your tax advisor.

# APPLICATION AFFIDAVIT

I, \_\_\_\_\_, being duly sworn according to law, do depose to say that all statements in the above Application and attachments are true and accurate to the best of my knowledge and belief. I have read the rules and standards of The CCN Study Guide, The CCN Professional Practice Guidelines, and The CNCB Discipline Policy. I comply with and agree to be bound by them.

I make this application for bona fide certification purposes only and will not disclose any information regarding the content of the examination, test questions, or test materials. I authorize The CNCB to communicate any actual or alleged violations of its rules or standards by me, the status of my application, and the pendency and outcome of any matters involving me to its certificants, state and federal authorities, employers, insurance companies, and other. I consent to and authorize The Clinical Nutrition Certification Board in its descretion to request information relevant to this application and my eligibility, certification, recertification, and review of certification and for any entity to furnish this information to The Clinical Nutrition Certification Board, its officers, directors, employees, committee members, and agents and any person furnishing documents, records and other information relating to my eligibility, certification, recertification, or review of certification, from any and all liability of any nature and kind arising out of furnishing or inspection of documents, records, and other information and any investigation and evaluation made by The Clinical Nutrition Certification Board.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

SWORN AND SUBSCRIBED before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_ My Commission Expires: \_\_\_\_\_

Notary Public

## ENDORSEMENT

I verify that the Applicant has fulfilled the Requirements for Certification as set forth by The Clinical Nutrition Certification Board. I verify that said Applicant holds a minimum Bachelor's Degree which includes CNCB required core courses. I have reviewed the Application, and to the best of my knowledge, it is complete.

\_\_\_\_\_  
Designated signature of  
Clinical Nutrition Certification Board  
Credentials Office

\_\_\_\_\_  
Date