

# Certified Hyperbaric Registered Nurse® Exam Registration Form

National Board of Diving & Hyperbaric Medical Technology  
9 Richland Medical Park, Suite 330, Columbia, SC 29203 USA  
Phone: (803) 434-7802 Fax: (866) 451-7231  
Email: nbdhmt@aol.com  
[www.nbdhmt.org](http://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;
- Current American Heart Association (AHA) Basic Life Support card/certificate. If certification is by another organization then a letter from your human resources director explaining non-AHA BLS as an organization policy.
- 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 with oversight by a CHRN preceptor (initial certification), recorded and signed by your medical director to include: dates, hours spent, and activities performed after attending the above referenced course. Utilize the BNACB hyperbaric experience log provided. The preceptor is not required to be employed on site but must validate initial certification applicants experience which the onsite medical director will confirm. Subsequent renewal of certification does not require a preceptor only medical director validation.

**Please reference Resource Manual for additional guidelines**

## Exam Location:

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip (Postal) Code: \_\_\_\_\_

Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_

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

State Board of Nursing License #: \_\_\_\_\_

Hyperbaric Medicine Course Attended : \_\_\_\_\_ Year: \_\_\_\_\_

Present Institutional Affiliation: \_\_\_\_\_

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

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

## Registration Fee

\*BNA Member (\$250.00 USD): \_\_\_\_\_

\*\*UHMS or \*\*\*ACHM Member (\$300.00 USD): \_\_\_\_\_

Non Member of organizations listed above(\$400.00) \_\_\_\_\_

Recertification is required every four years. If CHRN® certification lapses recertification may be obtained within one year from date of expiration. An additional reinstatement fee of \$50.00USD is charged. To become reinstated after a twelve-month period of inactive status requires a letter from the Manager/Medical Director validating the applicant's 480 hours of hyperbaric experience within the prior 12 months, retest of the CHRN® certification exam, and payment of recertification and reinstatement fees totaling \$300.00 with no discounts.

## Payment

\*Baromedical Nurses Association \*\*Undersea Hyperbaric Medical Society \*\*\*American College of Hyperbaric Medicine

Check of Money Order payable to NBDHMT  Credit Card  Visa  Mastercard

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ 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; 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.



# *Baromedical Nurses Association Certification Board*

## Hyperbaric (HBO) Experience Log

Date & Location	Start to Finish Time & Total Hours	Hours Directly Involved : HBO Assessment	Hours Directly Involved : Pre / Intra / Post HBO Patient Care	Hours Directly Involved (Define Below): HBO Technical / Maintenance / Safety / Administrative	Signed by CHRN Preceptor (CHT may sign for Technical & Maintenance) Must have a minimum of one CHRN preceptor.
IE. July 4, 2014 Naval Diving Salvage Training Center Panama City, FL	IE. 0700 - 1130 & 1230 - 1600 (8)				

- Renewal CHRN / ACHRN / CHRNC do not require a preceptor and may have the medical director acknowledge the attached log in their letter.

Candidate / Renewal CHRN Name: \_\_\_\_\_ Form # : \_\_\_\_\_ of \_\_\_\_\_

Preceptor(s) Name: \_\_\_\_\_ Preceptor(s) Active CHRN #: \_\_\_\_\_

Preceptor(s) Name: \_\_\_\_\_ Preceptor(s) Active CHRN #: \_\_\_\_\_