



Examination Application Form

Please read your Candidate Handbook before beginning the application process. The information you provide on this application must be complete, current, and accurate. If questions are left unanswered your application will not be processed. You must read and sign the Disclosure Statement at the end of this application. A checklist has been included for your convenience.

Mr. Mrs. Ms. Miss: _____
(Please separate credentials with commas)

Please check the date on which you plan to take the exam
 September 23, 2009 May 19, 2010

Social Security Number:

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First Name:

MI:

Last Name:

Title:

Affiliation:

Work Address:

City:

State:

Zip Code:

Work Phone Number:

Fax Number:

E-mail Address:

Home Address:

City:

State:

Zip Code:

Home Phone Number:

Fax Number:

Please mail my BASC information to Home or Work

Eligibility Requirements: Before completing the eligibility section, please read your Candidate Handbook. To be eligible to take the CASC examination, applicants must accumulate 100 points of experience, education, and/or other activities called eligibility points. The Candidate Handbook describes the rules for point accumulation. There is no need to include information beyond 100 points.

Candidate Name: _____

Eligibility Requirements

Social Security Number: - -

Education: Applicants obtain the number of eligibility points shown below for each degree that he or she has been awarded. For example, an applicant who has a Bachelor’s Degree in Nursing and an MBA will receive a total of 40 points. Each degree must be listed separately on the application.

Education	Institution*	Year Issued	Points	Points Earned
Associate’s Degree (other than nursing)			5	
Associate’s Degree in Nursing			15	
Bachelor’s Degree (other than nursing)			20	
Bachelor’s Degree in Nursing			25	
Juris Doctor			25	
Nursing Diploma			20	
Master’s Degree (other than those shown below)			10	
Master’s in Business Administration (MBA)			15	
Master’s in Health Care Administration			15	
Master’s Degree in Nursing			15	
Master’s in Hospital Administration			15	
Master’s of Public Health (MPH)			15	
Medical Degree			30	
			Sub-Total	

*Please do not abbreviate institutions name.

Experience: Applicants receive the number of eligibility points shown for each completed year of paid employment in that particular position. See Candidate Handbook for point calculations and examples.

Employer Name	Position Held	Year Ending	Year Beginning	Points Earned

Other: Applicants receive eligibility points for each credential or license listed below. To receive points for these items the license or credential must be valid at the time of application.

Licenses & Credentials	Issued by	Date Issued	Points	Points Earned
Bar Admission			10	
CNOR			10	
CNORFA			10	
CPA			10	
CPAN			10	
CRNA			10	
RN			10	
Completed 4 surveys of ASCs			10	
			Sub-Total	

Please total up your points from above and add them into the chart below:

Eligibility Point Calculation Chart	
Education	
Experience	
Licenses & Credentials	
Total Eligibility Points	

Candidate Name: _____

Social Security Number: - -

References: Two reference letters must be submitted with the application. Each reference letter must be signed, dated and on the signor's letterhead. The requirements for references are discussed in the Candidate Handbook. When submitting your application, complete the appropriate reference form and staple to the corresponding reference letter.

Note: Providing the following information is strictly voluntary. It will be used for statistical purposes only.

Gender: Male FemaleDate of Birth: / /

Special Accommodations Request: If you have a disability or special health care need that requires special accommodation in order for you to take the examination or access the testing location, complete the Special Accommodation Form and submit it with your application.

Disclosure Statement with Signature: BASC staff will select applications for random audit of information. This procedure may include: verifying applicant's education, license, or other credentials with educational entities, licensing authorities, and/or credentialing bodies; verifying current or previous experience with employer/employing facilities; or verifying references through contact. All information gained through the above procedures will be confidential except in instances where the law requires disclosure. If any information on the application is found to be falsified, misleading, or a misrepresentation of facts, the applicant will be declared ineligible to sit for the upcoming examination. I also acknowledge that BASC may withhold, cancel my scores, or take appropriate action including suspension or revocation of certification, if it is subsequently determined, in BASC's judgment, that any information presented in this application or the supporting documentation is false, deceptive or misleading. Applicants may be eligible to reapply after a certain time period, as determined by BASC on a case-by-case basis.

Signature: _____ Date: _____

Payment: \$750 must be submitted with the application. Payment may be made by check payable to BASC or a major credit card. If paying by credit card submit the Credit Card Authorization Form.

Checklist:

- I have completed, signed and dated the 3-page Candidate Application Form.
- I have Eligibility Points totaling 100.
- I have written a check for the correct amount or attached the completed Credit Card Authorization Form.
- I have included two Reference Forms with attached letters of reference.
- I have attached a legible copy of a government issued ID with a picture.
- If special accommodations will be needed, the Special Accommodations Form is attached.

Please mail you completed application to:

CASC Exam Registration
1012 Cameron Street
Alexandria, VA 22314

Contact Information: For questions regarding your application or program content contact BASC:
Via Phone: 703.836.4871, Via Fax: 703.549.0976, Via Email casc@aboutcasc.org, or at www.aboutcasc.org.

Candidate Name: _____

Social Security Number: - -

Special Accommodations Form

If you have a disability you believe is covered by the Americans with Disability Act, please complete this form and the Documents of Disability-Related Needs so your accommodations for testing can be processed efficiently.

Applicant Information:

First Name:

MI:

Last Name:

Home Address:

City:

State:

Zip Code:

Phone Number:

Fax Number:

BASC will comply with all federal regulations concerning the examination administration for qualified persons who are temporarily or permanently disabled at the time of the scheduled exam. A disability must be documented on official letterhead by a health care provider at the time the application is submitted to BASC, along with a Special Accommodations Form and Document of Disability-Related Needs. BASC reserves the right to consult its own physicians, other experts, or the person who has provided documentation of your disability in order to clarify information submitted or the recommendations for your testing needs and to request additional information to determine the accommodations. All determinations regarding accommodations to be offered to an individual will be made in BASC's sole discretion. The content and validity of the exam shall not be compromised by these accommodations. All reasonable attempts will be made to accommodate the needs of the disabled person. All information related to your request for accommodations will be kept strictly confidential unless you authorize its release or release is required by law.

Candidate Name: _____

Social Security Number:

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Document of Disability-Related Needs

The letter from your health care provider should be attached, along with the Special Accommodations Form.

Disability/Condition: _____

Reasons for needing special accommodation(s):

Accommodations requested: *(check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Accessible testing site | <input type="checkbox"/> Separate testing area |
| <input type="checkbox"/> Special seating | <input type="checkbox"/> Reader |
| <input type="checkbox"/> Large print test | <input type="checkbox"/> Other special accommodations (please specify) |
| <input type="checkbox"/> Circle answers in test booklet | _____ |
| <input type="checkbox"/> Extended testing time (time and a half) | _____ |

Comments:

By signing below, I attest that the information submitted is true and correct to the best of my knowledge. If this information is not sufficient, I authorize BASC to obtain additional information from the professionals who treated or evaluated my disability, other individuals who completed documents on my behalf related to this request, and/or BASC's own physicians or professionals. In addition, I authorize those persons who provide additional information to BASC to provide additional information if necessary for evaluating the appropriateness of the requested accommodation. I acknowledge that BASC reserves the right to make a final determination as to whether any requested accommodation is warranted and appropriate. I also acknowledge that BASC may withhold, cancel my scores, or take appropriate action including suspension or revocation of certification, if it is subsequently determined, in BASC's judgment, that any information presented in this application or the supporting documentation is false, deceptive or misleading.

Signature: _____ Date: _____