**MISSISSIPPI BOARD OF NURSING**
**713 Pear Orchard Road, Suite 300**
**Ridgeland, MS 39157**
**Telephone: (601) 957-6300**

## CERTIFIED CLINICAL HEMODIALYSIS TECHNICIAN (CCHT)

**INSTRUCTIONS:**

1. **SUBMIT** application after completion of an approved hemodialysis program.
2. **APPLICATION**: Enter data into form; use dropdown boxes to make selections. Incomplete applications will be returned.
3. **PHOTOGRAPH**: Attach, with transparent tape, a signed and dated 2" x 2" passport type photograph. Snapshots are NOT acceptable.
4. **AFFIDAVIT**: The application must be notarized.
5. **CCHT TRAINING TRANSCRIPT/VERIFICATION & EMPLOYMENT**: This form must be completed by the RN Educator/Clinic Manager for official evidence of completion of a hemodialysis technician program and/or evidence of being employed as a hemodialysis technician five (5) years of longer. This form must be sent directly from the training program to the board's office and must be NOTARIZED**. NOTE**: Supporting documents such as class content, employee records, etc., should **NOT** be sent to the board office unless requested. The CCHT training transcript/verification form serves as official written evidence of training program completion and/or employment five (5) or more years.
6. **HIGH SCHOOL DIPLOMA/GED:** Submit official written evidence of a minimum of a high school diploma/GED directly from the school (**copies not accepted**).
7. **AUTHORIZATION TO RELEASE INFORMATION**: Form must be completed, **NOTARIZED** and returned to the Mississippi Board of Nursing.
8. **CERTIFICATION: S**ubmit photocopy or proof of current certification from one of the following:
   - Nephrology Nursing Certification Commission (NNCC)
   - Board of Nephrology Examiners for Nursing and Technology (BONENT)
   - National Nephrology Certification Organization (NNCO)

10. **FEE:** Initial $50.00; Repeat $50.00; Endorsement $50.00; The fee is non-refundable. Include your phone number and social security number on your payment.

**TO APPLY FOR ENDORSEMENT**: The endorsement process is **only** for individuals who are currently nationally or state certified who have worked in another state and have never been certified as a CCHT in Mississippi.

Follow instructions as above. In addition you must:

- Submit official evidence from an employer of having worked as a hemodialysis technician within one (1) year preceding this application; and
- Send the attached verification of original certification form to the agency or Board of Nursing in the state where you were originally certified *if* that state regulates and certifies hemodialysis technicians.

**NOTE: Incomplete applications become null and void after one (1) year.**

**DO NOT RETURN THIS INSTRUCTION PAGE TO THE MISSISSIPPI BOARD OF NURSING.**

Non-Refundable Fee
$50.00

Click here to reset form

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**OFFICE USE ONLY**
CERT#: _____
DATE: _____

## CERTIFIED HEMODIALYSIS TECHNICIAN

Any statement made on this application which is false by the applicant at the time of making such statement shall be deemed fraudulent and will subject the applicant to disciplinary proceedings.

**I am applying for (select one):** Select one

NAME: First | Middle | Maiden | Last  DATE: mm/dd/yyyy

SOCIAL SECURITY #:  DATE OF BIRTH: mm/dd/yy

ADDRESS: Box/Apt/Street | City | State | Zip Code | County

PHONE: (Home #)  (Alternate #)  EMAIL:

PROGRAM NAME:  LOCATION:  DATE COMPLETED: mm/dd/yyyy

Have you been a hemodialysis technician for five (5) years or more? Select one

Have you taken an examination for CCHT in this or any other state? Select one **If YES**, fill in the box below:

Date of Examination: mm/dd/yyyy  Exam Type: Select one  State(s):

Status of Certification: Select one  Expiration Date of Certification: mm/dd/yyyy

1. Have you ever been convicted of, pled guilty or pled no contest to any charge(s), or are charges pending against you for a felony or misdemeanor, other than a minor traffic violation, in any state or jurisdiction? Select one
2. Have you ever been arrested or convicted for driving under the influence of drugs and/or alcohol? Select one
3. Have you ever been denied licensure/certification, had disciplinary action, or is action pending against you by a Board of Nursing or any other regulatory agency or certification organization in any state or jurisdiction? Select one
4. Have you ever voluntarily entered into an agreement restricting or monitoring your practice as a CCHT or hemodialysis technician in any state or jurisdiction? Select one
5. Have you ever been placed on a state and/or federal abuse registry? Select one
6. Have you within the last five years abused drugs/alcohol or been treated for dependency to alcohol or illegal chemical substances? Select one
7. Have you ever been disciplined by or administratively discharged by the military? Select one

If an answer to a question above is "**YES**", attach a detailed explanation and **certified** copies of all pertinent records, including but not limited to, any and all court and/or regulatory agency records from the applicable state or jurisdiction. Allow additional time for "YES" answers to be reviewed.

### AFFIDAVIT

Being duly sworn states that he/she is the person referred to in the foregoing application for licensure by examination as a CCHT or HCP in the State of Mississippi; that the statements herein contained are true to the best of his/her knowledge and belief; that he/she has complied with all requirements of the Law; that he/she has read and understands this Affidavit.

Signature of Applicant Print form to have notarized, sign/date, and submit

Sworn to and ascribed before me on this ____ day of _____month _____ year

Signature of Notary Public _____

My commission expires: _____ (SEAL)

**ATTACH ONE RECENT PASSPORT TYPE 2" x 2" PHOTOGRAPH SIGNED AND DATED ON BOTTOM OR SIDE**

Print form to have notarized, sign/date, and submit

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# AUTHORIZATION TO RELEASE INFORMATION

Please read the following release form carefully. Enter your name in the blanks and your signature, and the date in the designated spaces. **THIS FORM MUST BE NOTARIZED**.

TO WHOM IT MAY CONCERN:

I, _____, hereby authorize any and all individuals and entities to release to the Mississippi Board of Nursing and its staff, personnel and/or agents, ***any and all records and information***, whether it be academic, military, medical, psychiatric, psychological, drug/alcohol treatment, employment (including, but not limited to, applications for employment, payroll information, incident reports, drug screens, alcohol screens, contracts for employment, dates and hours worked, dates and hours of absences, reasons for days missed, appraisals and reprimands, promotions, complaints, identity of supervisors, illnesses, injuries, and my reasons for termination or leaving), judicial (including, but not limited to, investigatory agency and court criminal and civil records), or personal reference, and I, _____, being competent to grant this release, ***hereby fully authorize the release of any and all such information, privileged or otherwise***, to the **Mississippi Board of Nursing** and its staff, personnel, representatives and/or agents and fully release any and all persons or parties from any and all charges or liability whatsoever because of furnishing or releasing said information and/or documents. I further authorize the Mississippi Board of Nursing to release any and all information, including but not limited to, the above referenced records to individuals/entities and/or Mississippi Board of Nursing-approved assessors the Mississippi Board of Nursing deems necessary. This release shall remain in full force and effect until revoked in writing.

SIGNATURE:_____

PRINTED NAME:_____

SOCIAL SECURITY NUMBER: _____

DATE:_____

ATTORNEY'S SIGNATURE:_____
(if applicable)

STATE OF _____COUNTY OF _____

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named _____, who acknowledged to me that he/she signed and delivered the above and foregoing Authorization to Release Information form on the date therein mentioned and for the purpose therein expressed.

Given under my hand and seal of office, this the_____day of_____month _____year.

_____ NOTARY PUBLIC

_____ MY COMMISSION EXPIRES

(SEAL)

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# CCHT TRAINING TRANSCRIPT/VERIFICATION

To be completed by the RN Educator/Clinic Manager or designated authorized personnel.

Applicant's Name: _____ _____ _____
First Middle Last

Applicant's Date of Birth: _____
mm/dd/yy

**Program entry date:** _____ **Program completion date:** _____
mm/dd/yyyy mm/dd/yyyy

Select the appropriate verification

☐ **This is to certify that the above named CCHT applicant has successfully completed a hemodialysis technician training program with a minimum of eighty (80) hours of theory, a minimum of one hundred sixty (160) hours of supervised clinical experience prior to the final examination of the training program, and a minimum of six (6) months supervised clinical prior to the CCHT examination per 30 Miss. Admin. Code Pt. 2860, R 4.2.**

☐ **Theory waived. This is to certify that the above named CCHT applicant has five (5) or more years of experience and has successfully performed at least forty-five (45) RN supervised cannulations per 30 Miss. Admin. Code Pt. 2860, R1.1 (A)(2) in accordance with 30 Miss. Admin. Code Pt. 2860, R 4.2.**

☐ **Endorsement. This is to certify that the above named Mississippi CCHT applicant has worked as a CCHT within one (1) year preceding this application in a state <u>outside of Mississippi</u>, has successfully completed a CCHT training program, and has obtained CCHT certification from one of the following: NNCC, BONENT, or NNCO. *(NOTE: Official evidence of completion of a hemodialysis training program <u>MUST</u> be attached and submitted to the Board office by the employer and/or training program).***

By my signature below I certify that I am the RN Educator and attest that the above named applicant has successfully completed a board approved CCHT training program, and that the information provided is true and correct.

Print form to complete

RN Educator Signature _____

Printed Name _____

Position/Title _____

License Number _____

Facility _____

Facility Address _____

Facility Phone Number _____

Date _____

_____
Signature of Notary Public

**(SEAL)**

_____
My Commission Expires

This fom is ONLY for CCHT ENDORSEMENT

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This fom is ONLY for CCHT ENDORSEMENT

## CCHT ENDORSEMENT ONLY
## CCHT VERIFICATION OF ORIGINAL CERTIFICATION

Print form to complete and submit

**SECTION I**: Complete this form and submit to the State Board of Nursing or other regulatory agency where you were originally certified. Some agencies or Boards may charge a fee. You are responsible for any associated fees.

NAME: _____ _____ _____ _____
First Middle Maiden Last

ADDRESS: _____ _____ _____ _____ _____
Box/Apt/Street City State Zip Code County

Original Certificate Number _____ Social Security Number _____-_____-_____

**SECTION II**: To be completed by the State Board of Nursing or other regulatory agency where applicant was originally certified.

### TO BE COMPLETED BY THE ORIGINAL CERTIFICATION AGENCY

To be completed by the authorized representative of the Agency where the applicant was ORIGINALLY certified and forwarded directly to the Mississippi Board of Nursing, Attention: CCHT, 713 Pear Orchard Road, Suite 300, Ridgeland, MS 39157.

State of Registration:_____ Date of Registration: _____

Status of Certificate: ☐ Current ☐ Inactive Expiration Date: _____

Date of Examination: _____ Type of Exam: NNCC ☐ BONENT ☐ NNCO ☐

Has the certificate ever been **revoked** or has any **disciplinary action** been taken? NO ☐ YES ☐
If YES, attach details.

Is **disciplinary action pending**? NO ☐ YES ☐ If YES, attach details.

_____ _____
Signature of Authorized Representative Title of Authorized Representative

_____
Date

**AGENCY SEAL**