



Breast Patient Navigator Certification Program APPLICATION

CITY AND DATE SELECTION

___ Las Vegas, NV, March 10-11, 2012

Regional programs will be announced as they are determined.

CONTACT INFORMATION

First name _____ Last name _____
 Professional credentials certification/licensing (i.e., MD, RN, RT, LSW, NP) _____
 Professional title _____
 Facility name _____
 Department _____
 Facility mailing address _____ Suite number _____
 City _____ State _____ ZIP _____

Phone number _____ Cell phone number _____
 Fax number _____
 E-mail address _____
 Website _____
 Address to send program binder if different from business address _____
 Mailing address _____ Suite number _____
 City _____ State _____ ZIP _____

CERTIFICATION PROGRAM CRITERIA FOR APPLICATION CONSIDERATION

Required:

- I. ___ I am a licensed medical professional and hold a valid medical license, such as a physician, nurse, physician assistant, radiologic technologist or social worker **OR**
 ___ I am a certified medical professional and hold a valid certification, such as a radiologic technologist, radiology practitioner assistant, social worker, or advanced practice nurse **OR**
 ___ I am master level prepared in a health related field; **AND**
- II. ___ Breast patient navigation is at least 50% of my job responsibility **OR**
 ___ I have supervision of breast patient navigators; **AND**
- III. ___ I am providing a copy of my current license or certification; **AND**
- IV. ___ I agree to pay the certification fee per the schedule below.

Choose the type of breast center in which you perform navigation. Visit www.breastcare.org, which describes each type center in detail.

- ___ Screening Breast Center
- ___ Diagnostic Breast Center
- ___ Clinical Breast Center
- ___ Breast Cancer Treatment Center
- ___ Comprehensive Breast Cancer Treatment Center
- ___ Other: Describe _____

Identify the stages through which you navigate patients by number or number range using the breast patient Navigation Stages. To identify stages you navigate your patents visit <http://www.bpnc.org/NavStagesShort.htm>.

Length of time you have held professional licensure/certification _____
 Length of time you have been navigating _____

Recommended:

- ___ It is further suggested, but not mandatory: I have a minimum of at least two years of experience navigating breast patients.

I understand that this is a **Certification**, where my skills and knowledge as a Breast Patient Navigator **will be validated** by obtaining a minimum score of
 1) 80% on the imaging examination to be certified as a Breast Patient Navigator in Imaging (CBPN-I) or
 2) 80% on the cancer examination to be certified as a Breast Patient Navigator in Cancer (CBPN-C) or
 3) 80% on both the imaging and cancer examinations to be certified as a Breast Patient Navigator in Imaging and Cancer (CBPN-IC).

I understand that this program will provide patient navigation information and networking among peers but education is not being provided as a training program on how to become a navigator or how to start a navigation program. I further understand this is a certification and not an educational course.

Applicant signature required _____

PAYMENT INFORMATION

Regional program participation and examination is \$300 per person for members of NCBC or members of the Breast Patient Navigator Network. For non-members, the cost of program participation and examination is \$395, which includes membership into the Breast Patient Navigator Network for one year. Certification for those meeting the minimum standards of the program is considered "Life Time", renewable annually. Upon receipt of payment new "non Beta" applicants will be sent a program binder; beta applicants will receive an update to their initial binder at no cost.

2009 BETA Year Attendees FINAL OFFERING

- ___ \$150 registration any NCBC membership status
- ___ \$50 for a 2012 complete program binder

NON-BETA Year Attendees

- ___ \$300 registration for current NCBC/Nav members
- ___ \$395 registration for non-NCBC/Nav members
- ___ \$00 registration for retakes FINAL OFFERING

\$ _____ Total Amount

Payment Method

- ___ VISA, MasterCard, Discover, American Express
- ___ Payment by check
- ___ Payment is being processed by my facility
(Payment must be received prior to sitting for certification or credit card authorization must be on file to ensure payment.)

Submit Application to:

National Consortium of Breast Centers, Inc.
 US Mail: **P.O. Box 1334, Warsaw, IN 46581**
 Fed Ex: **1017 E Winona Ave, Warsaw, IN 46580**

Credit Card Information

Credit Card Number _____ *CVV2 # _____

Expiration Date _____

Print Card Holder's Name _____

Authorized Signature _____

* This is the 3-digit number on the back of all Visa, MasterCard and Discover Credit Cards, and the 4 digit number on the front of all American Express Credit Cards.

Fax: 574-267-8268 Voice: 574-267-8058
 Email: NCBC@breastcare.org
 Website: www.breastcare.org