Instrumental to Patient Care ®

CRCST

CERTIFIED CENTRAL SERVICE TECHNICIAN EXAMINATION APPLICATION

Incomplete applications will be returned. Complete all sections exactly to avoid disappointment. Please type or clearly print all information.

Section One – Applicant Information

Name: ______________________________ IAHCSMM ID # (if applicable): ______________

First and Last ONLY (as it appears on your primary photo ID)

Home Address: ____

Number & Street City, State, and Zip

Current Position in Hospital (circle one): Technician Supervisor Manager Other: ______________

Contact Information (please print clearly): ( ) ( ) ____________________

Home Phone Hospital Phone Ext. Email

Section Two - Hands on Experience

A minimum of 400 hours "Hands-On" experience must be documented prior to taking the IAHCSMM Technical Certification Exam. These hours must be applied to the specific areas mentioned below and each checked off and initialed by a direct Central Service Supervisor/Manager. (Those indicating Provisional Certification should skip to Section Four of the application. Provisional Certification applicants are required to accumulate these hours ***after*** passing the exam, and ***within*** 6 (six) months after passing). **Applications submitted without manager/supervisor documentation of hands on experience will be marked as Provisional (see Section Four)**, limiting your certification until all requirements of the application can be met, up to and including forfeiture of certification if hours can not be shown.

I. Patient Care Equipment (32 Hours) .... ❑ Initials ________
(Cleaning-Assembly/Testing Identification)

II. General Cleaning (32 Hours) .... ❑ Initials ________
(Instruments-utensils-specialty items, Operation of Mechanical Washers)

III. Wrapping Packaging (36 Hours) .... ❑ Initials ________
(Packaging Techniques; Pouches, Flat Wraps, and Rigid Containers; Label/Expiration Date, etc.)

IV. Linen Folding (36 Hours) .... ❑ Initials ________
(Inspection, Folding Drapes/Wrappers, Towels, etc.)
Note: If Facility does not have any reusable linen, these 36 hours will be divided in half (18 hours) and added to General Cleaning and Instrument/Procedure Trays

V. Assemble Instrument/Procedure Trays (60 Hours) .... ❑ Initials ________
(Assembly/Layout, Inspection, Identification, Use)

VI. Sterilization (64 Hours) .... ❑ Initials ________
(High Temperature and Low Temperature Sterilization Processes, Sterilization Quality Assurance Systems, Record Keeping, , Handling/Putting Away Sterile Supplies, Dust Covering)

VII. Storage Clean & Sterile (36 Hours) .... ❑ Initials ________
(Rotating Supplies, Inventory and Restocking Carts/Shelves, Outdates, Cleaning Storage Shelves)

VIII. Case Carts (32 Hours) .... ❑ Initials ________
(Assembly, Pick Sheets, Cover and Transport to OR)
Note: If Facility does not use case carts, these 32 hours will be divided in half (16 hours) and added to Wrapping/Packaging and Sterilization

IX. Distribution (32 Hours) .... ❑ Initials ________
(Par Levels, Point of Use Systems, Exchange Carts, Just In Time)
Note: If Facility does not use this procedure, these 32 hours will be divided in half (16 hours) and added to General Cleaning and Instrument/Procedure Trays

X. Miscellaneous (40 Hours) .... ❑ Initials ________
(Quality Assurance Processes, Blood Borne Pathogen Protocols, Soiled Equipment Pick-Up, Standards, Regulations, Policies and Procedures)

(OVER FOR SECTIONS 3-7)

Section Three – Manager/Supervisor Verification

Hospital where experience was obtained: ____________________

Address: ____________________ City/State/Zip: ____________________

Dates of Experience (starting to ending dates): ____________________

Supervisor/Manager verifying experience (print name)**:** ____________________

Print Title: ____________________ Signature: ____________________ Date:____________________

Telephone (with extension):____________________

Applications submitted without manager/supervisor verification of hospital employment will be marked as Provisional (see Section Four).

Section Four – Background Requirements (Please select any that apply from the following and sign where applicable)

❑ **Passed Technician Course:** ____________________ ____________________ ____________________
Location of Course | Instructor's Name | Dates

❑ **Provisional Certification:** 400 hours of Hands-On experience will be accumulated within six (6) months of a passing grade (70 or better) on the Certification Exam.These hours will be broken down specifically to the categories listed in the previous section. I will submit the further documentation to IAHCSMM Headquarters prior to the six (6) month expiration date. Failure to submit the hours within the designated time frame will result in a forfeiture of current certification, and successful completion of a retake exam will be required. All applicable fees will apply to this retake examination.

____________________ Applicant's Signature ____________________ Date

❑ **Challenge the Examination:** Currently employed in a hospital setting, and have accumulated the required 400 total hours of Hands-On experience, broken down specifically to the categories listed in the previous section. My current supervisor MUST initial and authorize my experience in Sections Two and Three. I have not taken or have not passed a Technician Course, but would still attempt a passing grade on the Certification Examination.

____________________ Applicant's Signature ____________________ Date

Section Five – Exam Type

❑ I have studied from the 6th Edition Central Service Technical Manual/Boxed Course or earlier editions, and will be taking the 6th Edition CRCST examination (Please note, all CRCST 6th Edition examinations must be taken by June 1, 2008 - no extensions will be honored).

❑ I have studied from the 7th Edition Central Service Technical Manual/Boxed Course, and will be taking the 7th Edition CRCST examination.

Please note, failure to indicate which exam edition will mark the application as incomplete, and may cause delays in the processing of your application.

Section Six – Payment Information (Note: IAHCSMM does not accept purchase orders of any kind)

Examination Fee is $105.00

You must include the fee of $105.00 with this application,in the form of: Personal Check, Money Order, Bank Draft, or Credit Card.

❑ My check,money order or bank draft is enclosed,and made payable to: IAHCSMM
❑ My credit card is to be charged,and I have supplied ALL necessary information below: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Name: ____________________
Please print name as it appears on credit card

____
Credit Card Account Number | Expiration | CVV2 Number (3-4 digit security code)

____________________ Signature ____________________ Billing Zipcode

Address provided must coincide with charge account information

Return applications with payment to: IAHCSMM, 213 West Institute Place, Suite 307, Chicago, IL 60610
Or Fax to: 312-440-9474 Attn: Examinations

Section Seven – Confirmation of Acceptance

Please print clearly (all Email confirmations are additionally mailed to the address listed in Section One):

❑ Please Email me:____________________
E-Mail Address

❑ Please Mail me (only if address is different then listed in Section One):

____
Address | City/State/Zip

The IAHCSMM complies with the Americans with Disabilities Act and is interested in ensuring that no disabled individual is deprived of the opportunity to take an examination solely by reason of that disability. Special testing accommodations may be made for these individuals. **If you require special accommodations, please request a Special Accommodations Form from IAHCSMM and submit with your application. (All special accommodation requests must be provided with each application submitted; applications received without this request will not be eligible for special accommodations).**