

**Certified Central Service Vendor Partner (CCSVP)** certification is designed to recognize vendors who have demonstrated knowledge of Central Service concepts and processes including the decontamination, inspection, assembly, packaging, and sterilization of reusable surgical instruments.

To earn CCSVP certification, candidates are required to successfully demonstrate knowledge through the completion of an online course, specific Central Service Department observations, and successful completion of an examination developed to measure the understanding of general central services and infection prevention topics. CCSVP are required to recertify annually through completion of continuing education requirements.

Once your application and payment have been received by IAHCSMM, processing will typically take 5-7 business days. Information on your exam eligibility period, scheduling your exam, available testing dates and locations, and the testing process will be mailed to the address provided in Section One. Please allow an additional 3-5 business days for this information to be delivered by the US Postal Service. You may also request the information be sent to you electronically by providing your email address(es) in Section One. Email notifications will be sent within 24 hours of application processing. (Scheduling information cannot be given by phone.) Once you receive your scheduling letter/email, it is your responsibility to schedule your exam.

### SECTION ONE – Applicant Information (To Be Completed By the Applicant)

**Please Note:** Incomplete or illegible applications can delay processing, clearly print all information

First Name: \_\_\_\_\_ Last Name(s): \_\_\_\_\_  
(As it appears on your primary government issued photo ID) (As it appears on your primary government issued photo ID)

Street Address: \_\_\_\_\_ Apt/Floor/Lot/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ USA or Canada

Current Company: \_\_\_\_\_ IAHCSMM ID# \_\_\_\_\_  
(You must be employed as a vendor in order to be eligible for CCSVP Certification) (Leave blank if unknown)

Current Position: \_\_\_\_\_

Home or Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Primary/Preferred Email: \_\_\_\_\_ Secondary/Alternate Email: \_\_\_\_\_  
(Optional) (Optional)

**Your exam scheduling information will be mailed to your home address, as listed above, and also emailed, if email is provided above.**

### SECTION TWO – Payment Information (To Be Completed by the Applicant or Payment Provider)

**Please Note:** IAHCSMM **cannot** accept purchase orders of any kind; if payment is required, it must be submitted along with this application

**One attempt at the exam is included in the cost of the CCSVP course, if this is your first time taking the exam this section should be left blank.** The examination fee for any additional attempts within the United States and Canada is \$125 USD. If you are retaking the exam payment must be submitted, along with this application, in the form of: Credit/Debit Card (US & Canada), Money Order (US & Canada), or Check (US only.) Payment **cannot** be made by phone.

- I am submitting a check or money order, made payable to IAHCSMM, by mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601
- I am submitting the credit/debit card information below and give permission for my card to be charged \$125 USD:  
Fax to: 1-312-440-9474, Scan & Email to: certification@iahcsmm.org, or Mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601

Credit/Debit Card Holder's Printed Name: \_\_\_\_\_

Credit/Debit Card Number: \_\_\_\_\_ Expiration: \_\_\_\_\_  
(Month/Year)

Credit/Debit Card Holder's Signature: \_\_\_\_\_ CV2#: \_\_\_\_\_  
(Handwritten Signature Required)

Upon passing the CCSVP exam, all applicants who are not already certified with IAHCSSM will be granted one year of complimentary membership with the Association. It is not required that you become an IAHCSSM member before taking the exam, nor is it required for you to maintain membership with IAHCSSM in order to be certified. If for any reason you prefer not to receive complimentary membership upon passing your certification exam please indicate so below.

- Yes;** I wish to receive complimentary 1 year IAHCSSM Membership after passing the CCSVP exam
- No;** I do not wish to receive complimentary IAHCSSM Membership after passing the CCSVP exam

### SECTION THREE – Background Requirements

#### Applicants for the CCSVP Exams must:

- Be currently employed as a vendor by a company that provides CS-related products or services
- Successfully complete the IAHCSSM online Central Service Vendor Partner education course
- Complete two 16 hour rounds of Clinical Observation Experience in two different CS facilities (as detailed in Sections Five A & B)

### SECTION FOUR – Statement of Understanding (To Be Completed By the Applicant)

**Please Note:** Your signature in this section is mandatory in order to test with IAHCSSM

#### Statement of Understanding

I hereby apply to take the CCSVP exam. By signing below and submitting an exam application and fee, I attest that I have read and understand the IAHCSSM Certification Handbook (available online at IAHCSSM.org) and agree to abide by the certification program's policies and procedures, and adhere to the Association's code of conduct. I agree to inform IAHCSSM, without delay, of any matter that affects my ability to fulfill the certification requirements.

I further certify that the information provided by and about me on this form (and any other subsequent documentation submitted in relation to my certification) is accurate and correct. I understand that the information I provide to IAHCSSM may be audited for verification. I agree to provide any information necessary to verify my experience and authorize IAHCSSM to make any necessary inquiries in this regard. I understand that providing information on this or any document relating to my certification which is determined to be false or purposefully misleading, or in violation of any portion of the Code of Conduct and/or other policies and procedures, may result in disciplinary action, including the possible denial or revocation of certification, as outlined in the disciplinary policy.

#### Release of Exam Results

I understand that a Pass/Fail notice will be issued at the testing center upon completion of the exam, and that IAHCSSM will only release my full exam results directly to me, in written format, at the home address provided herein. Results are not available orally or electronically, and can take up to two weeks to be delivered. Exam results and pass/fail notifications will not be provided to 3rd parties without my prior express written consent. Upon request IAHCSSM will verify an individual's current certification status (including their certification effective and expiration dates) to any inquiring party, but will not release the details of an individual's examination(s), including exam scores and the number of exam attempts.

#### Use of Personal Information

The information provided to IAHCSSM on this form, and in regard to my certification exam, will be used in accordance of IAHCSSM's Confidentiality Policy, included in the Certification Handbook and available online at IAHCSSM.org. If I request and am granted special testing accommodations IAHCSSM may disclose personal information to third parties as necessary to administer my examination. This may include such information as my disability status, medical condition, or any political, religious, or philosophical beliefs which require accommodation. If IAHCSSM is required by law to disclose confidential information, the individual(s) whose information is released will be notified to the extent permitted by law.

#### Non-Disclosure Agreement

This examination is confidential and proprietary. It is made available to me, the examinee, solely for the purpose of becoming certified in the technical area referenced in the title of this exam. I am expressly prohibited from recording, copying, reproducing, disclosing, publishing, or transmitting this examination, in whole or in part, in any form or by any means, verbal or written, electronic or mechanical, for any purpose.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Handwritten Signature Required)

**Please Note:** If the following page is not submitted, or if either section is left blank, your application will be returned, unprocessed. Likewise, if you, the applicant, complete any part of the following page, your application cannot be accepted. All observation experience must be completed in full before applying to take the CCSVP exam.

IAHCSSM complies with the Americans with Disabilities Act (ADA) and is interested in ensuring that no disabled individual is deprived of the opportunity to take an examination solely by reason of that disability. IAHCSSM will arrange to provide special testing accommodations for those individuals with a condition or disability as defined under the ADA. Accommodations will be provided at a designated testing center at no additional cost to the applicant. IAHCSSM's "Americans with Disabilities Policy Statement" can be found in full at IAHCSSM.org and in the Certification Handbook. If you believe that you qualify for an accommodation pursuant to the ADA, we ask that you contact IAHCSSM to request a Special Accommodations form, to be completed and submitted with your application.

**SECTION FIVE A – Clinical Observation (To Be Completed By the Manager/Supervisor of the CS Department)**

**Please Note:** All information in this section must be completed/initialed by the Manager/Supervisor who oversaw the applicant's observation

**The applicant cannot complete any part of this section**

**INSTRUCTIONS:** This section is to be completed by the CS Department Manager/Supervisor who oversaw the CCSVP applicant's observation. By completing this section you attest that the vendor has completed the observation experience listed below and will verify as much if called upon. Every line below must be completed, which includes initialing each area of observation to indicate that it has been met.

**Manager/Supervisor Initials**

- \_\_\_\_\_ **1. Decontamination (5 Hours)**  
Manual Cleaning Processes, Mechanical Cleaning Processes, and Disinfection
- \_\_\_\_\_ **2. Inspection, Assembly and Packaging (5 Hours)**  
Instrument Inspection, Testing and Assembly, and Packaging Methods
- \_\_\_\_\_ **3. Sterilization (4 Hours)**  
High and Low Temperature Sterilization and Sterility Assurance Systems
- \_\_\_\_\_ **4. Sterile Storage and Distribution Systems (2 Hours)**  
Sterile Storage, Inventory Management, and Distribution Systems

**Please Remember:** Every line in this section **must** be completed, and the applicant **cannot** complete any part of this section, whatsoever (not even their name or facility information.) Doing so may result in the application being returned, unprocessed.

Printed Name of Vendor Whose Experience Is Being Verified: \_\_\_\_\_

Facility Where Vendor's Observation Was Completed: \_\_\_\_\_

Facility Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates When Vendor's Observation Was Completed (must have occurred within the past 5 years): \_\_\_\_\_ to \_\_\_\_\_  
**Mandatory (Month/Date/Year)** **Mandatory (Month/Date/Year)**

Manager/Supervisor's Title Within the Department: \_\_\_\_\_ Date: \_\_\_\_\_

Mgr/Spv's Name & Signature: \_\_\_\_\_  
**Printed Name** **Signature**

Mgr/Spv's Contact Information: \_\_\_\_\_  
**Work Phone Number (with Extension)** **Work Email (Personal email accounts, such as gmail or yahoo, cannot be used)**

**SECTION FIVE B – Clinical Observation (To Be Completed By the Manager/Supervisor of the CS Department)**

**Please Note:** All information in this section must be completed/initialed by the Manager/Supervisor who oversaw the applicant's observation

**The applicant cannot complete any part of this section**

**INSTRUCTIONS:** This section is to be completed by the CS Department Manager/Supervisor who oversaw the CCSVP applicant's observation. By completing this section you attest that the vendor has completed the observation experience listed below and will verify as much if called upon. Every line below must be completed, which includes initialing each area of observation to indicate that it has been met.

**Manager/Supervisor Initials**

- \_\_\_\_\_ **1. Decontamination (5 Hours)**  
Manual Cleaning Processes, Mechanical Cleaning Processes, and Disinfection
- \_\_\_\_\_ **2. Inspection, Assembly and Packaging (5 Hours)**  
Instrument Inspection, Testing and Assembly, and Packaging Methods
- \_\_\_\_\_ **3. Sterilization (4 Hours)**  
High and Low Temperature Sterilization and Sterility Assurance Systems
- \_\_\_\_\_ **4. Sterile Storage and Distribution Systems (2 Hours)**  
Sterile Storage, Inventory Management, and Distribution Systems

**Please Remember:** Every line in this section **must** be completed, and the applicant **cannot** complete any part of this section, whatsoever (not even their name or facility information.) Doing so may result in the application being returned, unprocessed.

Printed Name of Vendor Whose Experience Is Being Verified: \_\_\_\_\_

Facility Where Vendor's Observation Was Completed: \_\_\_\_\_

Facility Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates When Vendor's Observation Was Completed (must have occurred within the past 5 years): \_\_\_\_\_ to \_\_\_\_\_  
**Mandatory (Month/Date/Year)** **Mandatory (Month/Date/Year)**

Manager/Supervisor's Title Within the Department: \_\_\_\_\_ Date: \_\_\_\_\_

Mgr/Spv's Name & Signature: \_\_\_\_\_  
**Printed Name** **Signature**

Mgr/Spv's Contact Information: \_\_\_\_\_  
**Work Phone Number (with Extension)** **Work Email (Personal email accounts, such as gmail or yahoo, cannot be used)**