Certified Endoscope Reprocessor (CER) certification is designed to recognize individuals who have demonstrated the knowledge and skills necessary to pre-clean, test, decontaminate, inspect, disinfect and/or sterilize, transport, and store endoscopes in accordance with industry standards, guidelines and regulations, and manufacturers’ instructions for use. CERs are crucial members of the healthcare team who are responsible for endoscope preparation, which is critical for patient safety in a healthcare facility.

To earn CER certification, candidates are required to successfully demonstrate skills through completion of hands-on work experience as well as successful completion of an examination developed to measure the understanding of endoscope care and handling and infection prevention. CERs 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 Facility (if employed): ___________________________ IAHCSMM ID# _________________________
(Leave blank if unknown)

Current Position (circle one): Student Technician Supervisor Manager Educator Other: ____________________________

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; payment must be submitted along with this application

The examination fee within the United States & Canada is $125 USD. 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 CER exam, all applicants who are not already certified with IAHCSMM will be granted one year of complimentary membership with the Association. It is not required that you become an IAHCSMM member before taking the exam, nor is it required for you to maintain membership with IAHCSMM in order to be certified. If for any reason you prefer not to receive complimentary membership upon passing the CER exam please indicate so below.

☐ Yes, I wish to receive complimentary 1 year IAHCSMM Membership after passing the CER exam
☐ No, I do not wish to receive complimentary IAHCSMM Membership after passing the CER exam
SECTION THREE – Statement of Understanding (To Be Completed By the Applicant)

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

Statement of Understanding
I hereby apply to take the CER exam. By signing below and submitting an exam application and fee, I attest that I have read and understand the IAHCSMM Certification Handbook (available online at IAHCSMM.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 IAHCSMM, 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 IAHCSMM may be audited for verification. I agree to provide any information necessary to verify my experience and authorize IAHCSMM 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 IAHCSMM 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 IAHCSMM 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 IAHCSMM on this form, and in regard to my certification exam, will be used in accordance of IAHCSMM's Confidentiality Policy, included in the Certification Handbook and available online at IAHCSMM.org. If I request and am granted special testing accommodations IAHCSMM 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 IAHCSMM 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)

SECTION FOUR – Hands-On Experience (To Be Completed By the Applicant’s Manager/Supervisor)

Please Note: All information in this section must be completed/initialed by the applicant’s Manager/Supervisor

The applicant cannot complete any part of this section

CER certification requires a minimum of three months’ experience reprocessing endoscopes on a regular basis in a medical center, hospital, surgery center, or independent endoscopic center. This work must have occurred within the past three years at most, and must include hands-on experience in each of the following areas: pre-cleaning, testing, decontaminating, inspecting, disinfecting and/or sterilizing.

INSTRUCTIONS: This section is to be completed by the Manager/Supervisor who supervised the CER applicant’s work/volunteer experience. Providing you are in a position above the applicant, this section can be completed by: Lead Techs, Coordinators, Supervisors, Managers, Directors, Chiefs, Administrators, or Hospital-Based Educators/Trainers. By completing this section you attest that the employee/volunteer listed below has completed the minimum three months of hands-on reprocessing experience, as outlined above, and will verify as much if called upon. The applicant cannot complete any part of this page whatsoever, and every line below must be completed.

Printed Name of Applicant Being Verified: ___________________________________________ IAHCSMM ID#: __________________________

(Leave blank if unknown)

Facility Where Applicant’s Experience Was Obtained: ____________________________________________________________

Facility Address: ______________________________________ City: ____________________ State/Province: _____ Zip/Postal Code: __________

Dates When Applicant’s Experience Was Obtained (must have occurred within the past 3 years): __________ to __________

Month/Date/Year Mandatory Month/Date/Year Mandatory

Is the Applicant a Current Employee of the Facility?  Yes ☐  No ☐

Printed Name of Manager/Supervisor Verifying Experience: ______________________________________________________

Mgr/Spv’s Title Within the Department: __________________________________________________________ Date: ______________

Mgr/Spv’s Signature: ___________________________________________ (Handwritten Signature Required)

Mgr/Spv’s Work Phone (with extension): (_______)____________________________

Personal phone numbers cannot be used (such as home or mobile)

Mgr/Spv’s Work Email: __________________________________________________________

Personal email accounts cannot be used (such as gmail, yahoo, hotmail, etc)

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.