

Certified Instrument Specialist (CIS) certification is designed to recognize individuals who have demonstrated the experience, knowledge, and skills necessary to provide competent services as an advanced instrument specialist in the Central Service Department. CIS's are essential members of the healthcare team who are responsible for demonstrating the knowledge and recognition of medical instruments and instrument support system functions necessary to help ensure the safe and timely delivery of surgical instruments to patients.

To earn CIS Certification, candidates are required to successfully demonstrate skills through the completion of hands-on work experience as well as the successful completion of an examination developed to measure the understanding of all instrument reprocessing functions (including instrument support system functions, instrumentation practice skills, knowledge and recognition of medical instruments, plus CS tech responsibilities.) CIS certificants are required to recertify annually through completion of continuing education requirements.

Please Note: Full CRCST certification is required before applying for the CIS. Once your application and payment have been received by IAHCSMM, processing will typically take 5-7 business days. Information on your 90 day 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 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 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: _____

Home Email: _____ (Optional) Work Email: _____ (Optional)

Your exam scheduling information will be mailed to your home address, as listed above, and also emailed, if home and/or work email are provided.

SECTION TWO – Payment Information (To be completed by 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 and 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#: _____

IAHCSMM 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. IAHCSMM 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. IAHCSMM's "Americans with Disabilities Policy Statement" can be found in full at IAHCSMM.org and in the Certification Handbook. If you believe that you qualify for an accommodation pursuant to the ADA, we ask that you contact IAHCSMM to request a Special Accommodations form, to be completed and submitted with your application.

For Office Use Only

S1 _____ S2 _____ S3 _____

S4 _____ S5 _____ RT _____

SECTION THREE – Background Requirements

Current CRCST status is required in order to apply for the Certified Instrument Specialist Exam.

If you do not already hold CRCST status then you would need to achieve full CRCST certification before you apply for the CIS.

SECTION FOUR – Statement of Understanding (To be completed by 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 CIS 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:** _____

SECTION FIVE – Hands-On Experience (To be completed by 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

INSTRUCTIONS: This section is to be completed by the Manager/Supervisor who oversaw the CIS 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 200 hours of hands-on experience required for this IAHCSSM certification and will verify as much if called upon. Every line below must be completed, which includes initialing each area of experience to indicate that it has been completed.

Manager/Supervisor Initials

_____ **1. Instrument Decontamination (92 Hours)**

Disassembly, Manual and Mechanical Cleaning Processes

_____ **2. Instrument Assembly (92 Hours)**

Identification, Inspection, Testing, Assembly, Packaging

_____ **3. Instrument Information System Management (12 Hours)**

Packaging Back Up Instrument System Maintenance, Form Maintenance, Change Notification Systems, Implant Replenishment, Loaner Instrument Processes

_____ **4. Surgery Observation (4 Hours)**

Applicants should observe room set up, sterile field set up, handling of instruments during surgery, instrument request processes, and care of instruments at the end of procedures

Printed Name of Applicant Whose Experience Is Being Verified: _____

Facility Where Applicant's Experience Was Obtained: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

Dates When Applicant's Experience Was Obtained (must have occurred within the past 5 years): _____ to _____
Mandatory (Month/Date/Year) **Mandatory** (Month/Date/Year)

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: _____

Mgr/Spv's Work Phone (with extension): (_____) _____
Mandatory

Mgr/Spv's Work Email: _____

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

Please Remember: The applicant **cannot** complete any part of this page whatsoever (including their name or facility information.) Doing so will result in the application being returned, unprocessed.