IAHCSMM
Instrumental to Patient Care®

# CCSVP Exam Application

Certified Central Service Vendor Partner Exam Application
for testing **OUTSIDE** the United States & Canada
Revised Jan 2017 3 Pages

**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 90 day exam eligibility period, scheduling your exam, available testing dates and locations, and the testing process will be sent to the email address(es) provided on the application. Once you receive your scheduling email, it is your responsibility to schedule your exam. **Certinfication exams CANNOT be given by proctor**; you must test at a Prometric Testing Center. To find the closest testing center to you please visit www.prometric.com/iahcsmm

## SECTION ONE – Applicant Information (To be completed by APPLICANT)

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

First Name(s): _____ Last Name(s): _____
**(As appearing on your primary goverment issued photo ID)** **(As appearing on your primary government issued photo ID)**

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

Company Address: _____
(Number, Street, and/or PO Box) (City, State/District & Postal Code) (Country)

Current Position: _____

Home Address: _____
(Number, Street, and/or PO Box) (City, State/District & Postal Code) (Country)

Home or Cell Phone: (_____)_____ Work Phone: (_____)_____ Ext: _____

Home Email: _____ Work Email: _____
(At least one email address, either home or work, is **mandatory**) (At least one email address, either home or work, is **mandatory**)

**Your exam scheduling information will be sent to the email address(es) listed above.**

## SECTION TWO – Payment Information (To be completed by APPLICANT or PAYMENT PROVIDER)

**Please note:** IAHCSMM can not 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 ***outside*** the United States and Canada is $150 USD. If you are retaking the exam payment must be submitted, along with this application, in the form of: Credit/Debit Card or Money Order (made payble in US dollars.)
**Payment CANNOT be made by phone.**

- ☐ I am submitting a money order, made payable to IAHCSMM, by mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601, USA
- ☐ I am submitting the credit/debit card information below and give permission for my card to be charged $150 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, USA

Credit/Debit Card Holder's Printed Name: _____

Credit/Debit Card Number: _____ Expiration: _____
**(Month/Year)**

Credit/Debit Card Holder's Signature: _____ CV2#: _____

**PLEASE NOTE:** This application is ***only*** for those individuals testing ***outside*** of the US & Canada
For those testing ***within*** the US or Canada, please download the CCSVP (US/Canada) application from IAHCSMM.org

**For Office Use Only**

S1_____ S2_____ S3_____

S4_____ S5A_____ S5B_____

Upon passing the CCSVP exam, you will be granted one year of complimentary membership with IAHCSMM in addition to your certification. 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 your certification exam please indicate so below.

☐ **Yes**; I wish to receive complimentary 1 year IAHCSMM Membership after passing the CCSVP exam
☐ **No**; I do not wish to receive complimentary IAHCSMM 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 IAHCSMM Online Central Service Vendor Partner Education Program
- 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 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 CCSVP 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 four 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:** _____

## 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 experience. 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**: The applicant **cannot** complete any part of this page whatsoever (including their name or your facility information.) Doing so will 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: _____
(Number, Street, and/or PO Box) (City, State/District & Postal Code) (Country)

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: _____ _____
**Hospital Phone Number** (with Extension) **Hospital-Based 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**

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(Number, Street, and/or PO Box) (City, State/District & Postal Code) (Country)

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: _____ _____
**Hospital Phone Number** (with Extension) **Hospital-Based Email** (Personal email accounts, such as gmail or yahoo, cannot be used)