



AMERICAN BOARD OF CERTIFICATION  
FOR GASTROENTEROLOGY NURSES

## Recertification Pre-Review Application

Yes, I would like to have my contact hours reviewed by a member of the Recertification Committee prior to submitting them for certification renewal. I understand that there is a \$50.00 fee for this service.

I understand that this is a preliminary review done by an experienced member of the Recertification Committee and not a complete review by the full committee. Therefore, ABCGN makes no claims or warranties regarding the comments, suggestions or results of the pre-review screening. Its purpose is only to provide additional information to candidates in making their choice of whether to seek recertification by contact hours or by examination or in preparing their packet for submission.

### Contact Hours Recertification Requirements

The candidate seeking recertification status from the American Board of Certification for Gastroenterology Nurses must submit documentation of 100 Contact Hours within the five year period prior to the certification expiration date in order to maintain his/her certification. At least eighty (80) contact hours must be GI-specific and at least 40 of the GI-specific contact hours must have been earned through attendance at approved nursing seminars and workshops (Category 1).

### Please Print Legibly or Type All Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: Work (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_

Date of Initial Certification: \_\_\_\_\_

### • DIRECTIONS

1. Attach copies of all documents verifying continuing education activities to this form in order. **Do not send original certificates.**
2. Submit the original of this form, retaining a copy for your records, with your payment of \$50.00, made payable to ABCGN.

\*\* Recertification Pre-Review Applications may be submitted at any time; however, please allow sufficient time for the Recertification Audit Committee to review your application and respond to you so that you can, if necessary, register for the exam or correct deficiencies prior to the deadline for recertification by contact hours.

Mail payment to:

ABCGN  
330 N. Wabash Ave., Suite 2000  
Chicago, IL 60611

3. Please note that this is only a recertification pre-review. Should you decide to recertify by contact hours you will be required to complete a recertification application and submit the appropriate fees by the scheduled deadlines.

# Category 1:

Attendance at Nursing CE Approved Seminars / Workshops (Minimum: 40 GI-Specific contact hours)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

## Category 2:

Providing Presentations (Minimum: None - Maximum: 50)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

# Category 3:

Professional Publications (Minimum: None - Maximum: 50)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

# Category 4:

Academic Credit Course Work (Minimum: None - Maximum: 20)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

# Category 5:

Continuing Education Independent Home Study (Minimum: None - Maximum: 60)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						



# Category 6:

CBGNA Item Writers Workshop (Minimum: None - Maximum: 20)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

# Category 7:

Continuing Medical Education (CME's) (Minimum: None - Maximum: 30)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

# Category 8:

Nursing Research Projects (Minimum: None - Maximum: 40)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

# Category 9:

Poster Presentation (Minimum: None - Maximum: 10)

Program Title	Date(s)	Sponsoring Organization	Number of Approved Credits	GI Credits	Non-GI Credits	OFFICE USE ONLY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

**Verification Form Poster  
Presentations ABCGN**

Name: \_\_\_\_\_

Check One:  GI Specific  Non GI Specific

Contact hours claimed for this poster presentation: \_\_\_\_\_

Please complete a separate form for each poster presentation.

Title of poster presentation: \_\_\_\_\_

Where presented: \_\_\_\_\_

When presented: \_\_\_\_\_

Abstract included  Photo of poster included

Signature: \_\_\_\_\_

*Signature verifies I was involved in developing and presenting this poster.*

**Documentation required if audited**

# Category 10:

## Preceptorship (Minimum: None – Maximum: 5)

Five (5) Contact Hours will be awarded to the CGRN for **80** hours of precepting an RN/LPN/GI Tech within a GI work setting. A GI work setting is defined as working in a Gastroenterologist Office or GI Unit (Hospital or Ambulatory Surgery/Endoscopy Center). The maximum amount awarded is **5** GI Specific contact hours, in a **5** year period. No contact hours will be awarded for Non-GI work settings.

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I VERIFY THAT (NAME)

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SERVED AS A PRECEPTOR FOR STAFF MEMBER (RN, LPN, TECH)

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FROM: (DATE TO DATE) FOR A **MINIMUM** OF 80 HOURS

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SIGNATURE OF NURSE MANAGER/DIRECTOR

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NAME/ADDRESS OF INSTITUTION

---

CONTACT NUMBER

DATE

---

SIGNATURE OF CGRN

CONTACT NUMBER

DATE

***My signature attests to the fact that the information provided is accurate.***

# Category 11:

Volunteer involvement in these professional organizations or publications by ABCGN, SGNA, or SIGNEA may be included in Category 11.

Three (3) contact hours per year will be awarded for involvement in these GI focused professional organizations as an officer, committee/task force member at the regional or national level or as an appointed publication editor/reviewer. Minimum GI specific hours granted will be 3, maximum 15. Non-GI specific contact hours will not be awarded. (Item Review Committee and Item Writing Panel use Category 12.)

## VERIFICATION OF INVOLVEMENT IN A PROFESSIONAL ORGANIZATION:

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I VERIFY THAT (NAME)

---

HAS SERVED AS AN OFFICER  
(NAME OF OFFICE HELD/ORGANIZATION)

DATES OF SERVICE

---

HAS SERVED AS A COMMITTEE/TASK FORCE MEMBER  
(NAME OF COMMITTEE/TASK FORCE)

DATES OF SERVICE

---

NAME OF GI FOCUSED PROFESSIONAL ORGANIZATION

---

VERIFICATION SIGNATURE (to be signed by an officer of organization)

TITLE

---

ORGANIZATION

TELEPHONE

DATE

---





CGRN SIGNATURE

DATE

*My signature attests to the fact that the information provided is accurate.*

# Category 12:

## **ABCGN Test Development (Minimum: None – Maximum: 48)**

Up to twelve (12) GI Specific contact hours per year will be awarded for participation on the Item Review Committee and/or Item Writers Panel. You can submit up to a maximum of 48. You will be awarded a certificate to present with recertification.

### **The attached certificate verifies that:**

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NAME

---

HAS SERVED AS A MEMBER OR CHAIR OF THE ABCGN ITEM REVIEW COMMITTEE

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HAS SERVED AS A MEMBER OF THE ABCGN ITEM WRITERS PANEL

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DATES OF SERVICE

---

CGRN SIGNATURE

DATE

*My signature attests to the fact that the information provided is accurate.*

# Category 13:

**Involvement in other GI related organizations or publications may be included in Category 13 for involvement as an officer, committee/task force member at the regional or national level or as an appointed publication editor/reviewer.  
(Minimum: None - Maximum: 10)**

## VERIFICATION OF INVOLVEMENT IN A PROFESSIONAL ORGANIZATION:

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I VERIFY THAT (NAME)

---

HAS SERVED AS AN OFFICER  
(NAME OF OFFICE HELD/ORGANIZATION)

DATES OF SERVICE

---

HAS SERVED AS A COMMITTEE/TASK FORCE MEMBER  
(NAME OF COMMITTEE/TASK FORCE)

DATES OF SERVICE

---

NAME OF GI FOCUSED PROFESSIONAL ORGANIZATION

---

VERIFICATION SIGNATURE (to be signed by an officer of organization)

TITLE

---

ORGANIZATION

TELEPHONE

DATE

---

CGRN SIGNATURE

DATE

*My signature attests to the fact that the information provided is accurate.*

