



CRCST
(United States and
Canada only)

CERTIFIED CENTRAL SERVICE TECHNICIAN EXAMINATION APPLICATION

Instrumental to Patient Care®

Incomplete applications will be returned. Complete all sections exactly to avoid disappointment. Please type or clearly print all information.

Section One – Applicant Information

Name: _____ IAHCSMM ID # (if applicable): _____
First and Last ONLY (as it appears on your primary photo ID)

Home Address: _____
Number & Street City, State, and Zip

Current Position in Hospital (circle one): Technician Supervisor Manager Other: _____

Contact Information (please print clearly): () () _____
Home Phone Hospital Phone Ext.

Email: _____ **Please email my confirmation (Check here)**

Section Two – Payment Information (Note: IAHCSMM does not accept purchase orders of any kind)

Examination Fee is \$105.00

You must include the fee of \$105.00 with this application, in the form of: Personal Check, Money Order, or Credit Card.

- My check or money order is enclosed, and made payable to: IAHCSMM
- My credit card is to be charged, and I have supplied ALL necessary information below: Visa MasterCard American Express Discover

Name: _____
Please print name as it appears on credit card

_____ _____ _____
Credit Card Account Number Expiration CVV2 Number (3-4 digit security code)

_____ _____
Signature

**Return applications with payment to: IAHCSMM, 213 West Institute Place, Suite 307, Chicago, IL 60610
Or Fax to: 312-440-9474 Attn: Examinations**

Section Three – Background Requirements (Please select any that apply from the following and sign where applicable)

- Passed Technician Course:** _____
Location of Course Instructor's Name Date of Course
- Provisional Certification:** 400 hours of Hands-On experience will be accumulated within six (6) months of a passing grade (70 or better) on the Certification Exam. These hours will be broken down specifically to the categories listed in the previous section. I will submit the further documentation to IAHCSMM Headquarters prior to the six (6) month expiration date. Failure to submit the hours within the designated time frame will result in a forfeiture of current certification, and successful completion of a retake exam will be required. All applicable fees will apply to this retake examination.
- _____ _____
Applicant's Signature Date
- Challenge the Examination:** Currently employed in a hospital setting, and have accumulated the required 400 total hours of Hands-On experience, broken down specifically to the categories listed in the previous section. My current supervisor MUST initial and authorize my experience in Sections Two and Three. I have not taken or have not passed a Technician Course, but would still attempt a passing grade on the Certification Examination.
- _____ _____
Applicant's Signature Date

(OVER)

All Applicants must complete the reverse side of this application to indicate hours of experience and location of hospital where experience was earned. (Failure to complete the second page of the application will result in assignment of Provisional certification if a passing score is received for the exam. Specification of Provisional Certification can be found in Section Three of the application).

Section Four - Hands on Experience

A minimum of 400 hours "Hands-On" experience must be documented prior to taking the IAHCSSM Technical Certification Exam. These hours must be applied to the specific areas mentioned below and each checked off and initialed by a direct Central Service Supervisor/Manager. (Those indicating Provisional Certification should see Section Two of the application. Provisional Certification applicants are required to accumulate these hours **after** passing the exam, and **within** 6 (six) months after passing). **Applications submitted without manager/supervisor documentation of hands on experience will be marked as Provisional (see Section Three)**, limiting your certification until all requirements of the application can be met, up to and including forfeiture of certification if hours can not be shown.

- I. Patient Care Equipment (32 Hours)** Initials _____
(Cleaning-Assembly/Testing Identification)
- II. General Cleaning (32 Hours)** Initials _____
(Instruments-utensils-specialty items, Operation of Mechanical Washers)
- III. Wrapping Packaging (36 Hours)** Initials _____
(Packaging Techniques; Pouches, Flat Wraps, and Rigid Containers; Label/Expiration Date, etc.)
- IV. Linen Folding (36 Hours)**..... Initials _____
(Inspection, Folding Drapes/Wrappers, Towels, etc.)
Note: If Facility does not have any reusable linen, these 36 hours will be divided in half (18 hours) and added to General Cleaning and Instrument/Procedure Trays
- V. Assemble Instrument/Procedure Trays (60 Hours)** Initials _____
(Assembly/Layout, Inspection, Identification, Use)
- VI. Sterilization (64 Hours)** Initials _____
(High Temperature and Low Temperature Sterilization Processes, Sterilization Quality Assurance Systems, Record Keeping, , Handling/Putting Away Sterile Supplies, Dust Covering)
- VII. Storage Clean & Sterile (36 Hours)** Initials _____
(Rotating Supplies, Inventory and Restocking Carts/Shelves, Outdates, Cleaning Storage Shelves)
- VIII. Case Carts (32 Hours)** Initials _____
(Assembly, Pick Sheets, Cover and Transport to OR)
Note: If Facility does not use case carts, these 32 hours will be divided in half (16 hours) and added to Wrapping/Packaging and Sterilization
- IX. Distribution (32 Hours)** Initials _____
(Par Levels, Point of Use Systems, Exchange Carts, Just In Time)
Note: If Facility does not use this procedure, these 32 hours will be divided in half (16 hours) and added to General Cleaning and Instrument/Procedure Trays
- X. Miscellaneous (40 Hours)** Initials _____
(Quality Assurance Processes, Blood Borne Pathogen Protocols, Soiled Equipment Pick-Up, Standards, Regulations, Policies and Procedures)

Section Five – Manager/Supervisor Verification

Where experience was obtained: _____

Address: _____
Number & Street City, State, and Zip (or Postal Code) Country

Dates of Experience (starting to ending dates): _____

Name of Supervisor/Manager verifying experience (print name): _____

Print Title: _____ Signature: _____ Date: _____

Telephone (with extension): _____ Email: _____

Applicant is a current employee of this hospital Yes No If No, please provide current hospital of employment:

Hospital Name: _____

Address: _____
Number & Street City, State, and Zip (or Postal Code) Country

Applications submitted without manager/supervisor verification of hospital employment will be marked as Provisional (see Section Two).

All Applicants must complete this side of the application to indicate hours of experience and location of hospital where experience was earned. (Failure to complete this page of the application will result in assignment of Provisional certification if a passing score is received for the exam. Specification of Provisional Certification can be found in Section Three of the application).

Notification of eligibility dates for the examination and scheduling information will be mailed to the address listed in Section 1. To ensure faster delivery, be sure to indicate you wish an additional email confirmation (Section 1) and provide a valid email address.

To receive the \$105 rate for examinations, your exam must be taken at a Prometric testing site in the United States (Continental plus Alaska, Hawaii, and Puerto Rico) or Canada.

The IAHCSSM complies with the Americans with Disabilities Act and is interested in ensuring that no disabled individual is deprived of the opportunity to take an examination solely by reason of that disability. Special testing accommodations may be made for these individuals. If you require special accommodations, please request a Special Accommodations Form from IAHCSSM and submit with your application. (All special accommodation requests must be provided with each application submitted; applications received without this request will not be eligible for special accommodations).