Continuing Education for Nursing Certifications
Bridgeport Hospital School of Nursing Alumnae Association 1, Inc.
***(All areas must be completed in its entirety for* EACH *certification with accompanying documentation)*.**

Last Name First Name Middle Initial Maiden Name

Address: Number & Street City State Zip Code

Telephone- Home: _____ Cell: _____

Email: _____

BHSN Class of:_____ BHSN Alumnae 1 member: ____ Yes ____ No

Are you currently employed: ___Yes ___No Name of Employer: _____

CERTIFICATION: ____Initial Certification ____Recertification

Certification Reimbursement from Employer: ___Yes ___No Amount received: _____

Total amount paid out of pocket for above certification after Employer reimbursement: _____

Name of Accredited Certifying Organization: _____

Name of Specialty Certification obtained: _____

Cost of Initial Preparation Course (if applicable): _____

Cost of Initial Certification Exam: _____

Cost of Recertification: _____

SUBMIT THE FOLLOWING DOCUMENTS:

-Receipt of preparation course (if applicable)

-Receipt of Initial Certification exam

-Receipt of Recertification

-Receipt of Employer Reimbursement (if applicable)

-Copy of valid document of Certification/Recertification

Please complete all information, then submit application to: Edi Poidomani (Chairman Certification Committee), at

5 Curry Drive, Newtown, Ct.06470, or email to: edisr@sbcglobal.net

Signature: _____

Date: _____

7/2024