MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road, Suite 300
Ridgeland, MS 39157
(601) 957-6300

CCHT TRAINING TRANSCRIPT/VERIFICATION

To be completed by the RN Educator/Clinic Manager or designated authorized personnel.

Applicant's Name: _____ _____ _____
First Middle Last

Applicant's Date of Birth: _____
mm/dd/yy

Program entry date: _____ **Program completion date:** _____
mm/dd/yyyy mm/dd/yyyy

Select the appropriate verification

☐ **This is to certify that the above named CCHT applicant has successfully completed a hemodialysis technician training program with a minimum of eighty (80) hours of theory, a minimum of one hundred sixty (160) hours of supervised clinical experience prior to the final examination of the training program, and a minimum of six (6) months supervised clinical prior to the CCHT examination per 30 Miss. Admin. Code Pt. 2860, R 4.2.**

☐ **Theory waived. This is to certify that the above named CCHT applicant has five (5) or more years of experience and has successfully performed at least forty-five (45) RN supervised cannulations per 30 Miss. Admin. Code Pt. 2860, R1.1 (A)(2) in accordance with 30 Miss. Admin. Code Pt. 2860, R 4.2.**

☐ **Endorsement. This is to certify that the above named Mississippi CCHT applicant has worked as a CCHT within one (1) year preceding this application in a state <u>outside of Mississippi</u>, has successfully completed a CCHT training program, and has obtained CCHT certification from one of the following: NNCC, BONENT, or NNCO. *(NOTE: Official evidence of completion of a hemodialysis training program <u>MUST</u> be attached and submitted to the Board office by the employer and/or training program).***

By my signature below I certify that I am the RN Educator and attest that the above named applicant has successfully completed a board approved CCHT training program, and that the information provided is true and correct.

Print form to complete

RN Educator Signature _____

Printed Name _____

Position/Title _____

License Number _____

Facility _____

Facility Address _____

Facility Phone Number _____

Date _____

_____
Signature of Notary Public

(SEAL)

_____
My Commission Expires