



IBLCE: APPLICATION TO RECERTIFY 2.10

(by **EXAM** or by **CERPs**)

Please read the Recertification Application Supplement specific to your country, which tells you about fees, deadlines and the address to which your application should be sent.

1. IDENTIFICATION DETAILS: IBCLC Number ___ - ___ - ___ Female Male

GIVEN NAMES (IN FULL)															
FAMILY/ SURNAME															

Please tick this box if you would prefer your family name to appear before your given names

Preferred given Name/Known by: _____

Preferred Title (e.g. Mrs, Ms, Miss, Mr, Dr): _____

2. POSTAL ADDRESS: _____

PHONE (home): _____

PHONE (work): _____

POST CODE: _____ **COUNTRY:** _____

MOBILE: _____

3. I AM APPLYING TO RECERTIFY:

4. EXAM SITE [If recertifying by exam] :

Write in the name of your exam site city (Closest Capital City)

- by **CERPs** within **5 years** after last sitting the for exam
- by **EXAM** within **5 years** after last sitting the for the exam
- by **exam** within **10 years** after last sitting for the exam

Preferred exam site _____

My First Language is: _____

My Primary language is: _____

The language I wish to sit the exam is: _____

I have been continuously certified an a IBCLC since _____

I have previously recertified in 19____ 19____ 20____ 20____

EMAIL: _____

- I request special arrangements on the basis of my disability. I enclose further information and supporting documentation.
- I may need special consideration on the exam day because I am pregnant. Due: _____
- I wish to do the exam in a language other than English, namely _____. I understand that, if there are not enough applicants wishing to do the exam in this language, there will not be a translation offered, and IBLCE will contact me about my options.
- I wish to use a bilingual dictionary during the exam.

5. RECERTIFICATION FEE: You must pay the full fee that corresponds to the deadline by which your application is postmarked. (See the Recertification Application Supplement for current fees and deadlines.)

Is your fee being paid or reimbursed by your employer or another agency? **Yes** **No** If Yes: **Full** **Part**

If you are not the payer, please state the name of the person or organisation paying _____

OFFICE USE ONLY Postmarked:	E S L \$	Receipt #:	Date Received:
ID#:			
Follow Up:			

6. CERPs RECORD AND CALCULATION:

Name: _____

Complete this section only if you are recertifying by CERPs

Write in the details of each program for which you are claiming CERPs. Please write the ID numbers for each line on the corresponding documents and file them in the same order to facilitate matching. List in chronological order. Please send only photocopied certificates or documents NOT originals

ID #	DATE	ORGANISATION	TITLE OF SESSION OR PROGRAM	PRESENTED BY/ CERPs APPROVAL #	L CERPs	E CERPs	R CERPs
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

19							
20							
21							
22							
23							
24							
25							
					CATEGORY L CERPS (minimum 50)		
					CATEGORY E CERPS (minimum 5)		
					CATEGORY R CERPS (maximum 20)		
					TOTAL NUMBER OF L, E & R CERPs (minimum 75)		

7. CURRENT LACTATION CONSULTANT STATUS: Tick **one** box that best applies to your current situation:

- I currently function as a paid lactation consultant averaging _____ hours per week (incl. private practice).
- I do not currently function as a paid lactation consultant
- I use my lactation consultant skills in another paid capacity (e.g. while employed as a midwife)
- I use my lactation consultant skills in a volunteer capacity

<p>Is your current work as a Lactation Consultant dependent on your IBCLC certification?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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8. PRINCIPAL CURRENT EMPLOYMENT SETTING:

Tick **one** box that best indicates the setting in which you currently work:

- | | | |
|---|--|--|
| <input type="checkbox"/> Hospital - maternity (all areas) | <input type="checkbox"/> Maternal & child health | <input type="checkbox"/> Medical practice |
| <input type="checkbox"/> Hospital - postnatal only | <input type="checkbox"/> Health visitor | <input type="checkbox"/> Private practice |
| <input type="checkbox"/> Hospital - general | <input type="checkbox"/> Clinic / community setting | <input type="checkbox"/> Mother support group |
| <input type="checkbox"/> Hospital - paediatric | <input type="checkbox"/> Postnatal domiciliary | <input type="checkbox"/> Educational institution |
| <input type="checkbox"/> Hospital - NICU / SCN | <input type="checkbox"/> Birthing centre / home births | <input type="checkbox"/> Independent educator |
| <input type="checkbox"/> Other (please describe) | | |

9. CURRENT WORKPLACE:

Name and address of your current workplace, including section or location (e.g. unit or clinic):

10. PROFESSIONAL DETAILS: Tick one or more of these boxes:

- | | |
|---|---|
| <input type="checkbox"/> IBCLC | <input type="checkbox"/> Health Visitor |
| <input type="checkbox"/> Bachelor of Nursing or similar university degree | <input type="checkbox"/> Enrolled Nurse or Mothercraft Nurse |
| <input type="checkbox"/> Registered Nurse (including NZ Plunket Nurse) | <input type="checkbox"/> Dietician, Occupational, Speech or Physiotherapist |
| <input type="checkbox"/> Registered Midwife | <input type="checkbox"/> Medical Practitioner |
| <input type="checkbox"/> Child & Family Health Nurse or similar qualification | <input type="checkbox"/> Accredited mother support counsellor/leader |
| <input type="checkbox"/> Other (please describe) | |

Tick **one** box which indicates your highest level of education:

- Doctoral Degree in
- Master's Degree in
- Bachelor Degree in
- Graduate Diploma in
- Tertiary Diploma/Registration e.g. RN or RM
- Other (please describe)

11: TERMS AND CONDITIONS: Please read the following statements carefully; and then sign and date at the bottom of the page. Any disputes arising hereunder will be settled in a court of law in Fairfax County, Virginia, USA. **Failure to sign and date at the bottom of this page will delay processing of your application and result in additional fees.**

I WISH TO APPLY for recertification by rather sitting for the IBLCE Certification Examination or by providing the required evidence for recertification by education. I acknowledge that the exam is held only on one date each year (the last Monday in July) and offered in a multiple-choice format only.

I CERTIFY THAT the information provided in and with this application is correct and includes all relevant information.

I UNDERSTAND THAT my application may be audited. If my application is audited, I will be required to provide sufficient information to prove my eligibility. I also understand that if the information and documentation I provide is not sufficient, I will not be permitted to take the exam.

I AGREE TO the IBLCE's recertification fees, closing dates for applications and all policies, all as outlined in the current Exam Application Guide, the current Application Supplement and current Exam Payment Form specific to my country. I understand that I will be subject to consequences if I fail to comply with these policies.

I AGREE THAT, if I successfully pass the recertification process, my name will become a part of the list of certificants, and that the IBLCE reserves the right to provide verification of certified individuals in the interests of public protection.

I AGREE TO be governed by the Code of Ethics for International Board Certified Lactation Consultants during the period of my certification and to be governed by the IBLCE Disciplinary Procedures for any violations of the Code of Ethics for International Board Certified Lactation Consultants. Furthermore, should an ethics complaint be filed against me, I understand that I have a duty to participate in and cooperate with the disciplinary process. (Please refer to www.iblce.edu.au for a copy of the Code of Ethics and the IBLCE Disciplinary Procedures).

I KNOWINGLY AND INTENTIONALLY WAIVE any rights I have under applicable law to request, review or receive any specific information regarding the wording or content of a question or the image or content of a photograph which is part of the IBLCE exam item bank, since I understand that IBLCE must keep this information confidential in order to preserve the integrity of the exam process.

I AGREE THAT, after reviewing this application and accompanying documentation, the IBLCE may make additional inquiries as it deems appropriate to verify the information I have provided and to ascertain my character and fitness to engage in the practice of lactation consultation. I understand that I may be disqualified on the basis of conduct that is immoral, unprofessional, dishonest, or contrary to fitness to practice as a lactation consultant.

I UNDERSTAND THAT the IBLCE considers satisfactory mental health to be a prerequisite for certification, including the current absence of an untreated, uncontrolled mental illness that impairs or limits an applicant's ability to practice as a lactation consultant in a competent and professional manner, and the unlikelihood of a relapse of any such prior mental illness.

I UNDERSTAND THAT the primary way in which the IBLCE staff will communicate with me is through email. Accordingly, I understand that the IBLCE respects the privacy of individuals and has implemented a privacy policy to ensure that the IBLCE collects, processes, and uses personal information in a manner that conforms to the highest standards. (This Privacy Policy is available at www.iblce.edu.au)

I AGREE THAT any disputes arising hereunder will be settled in a court of law in Fairfax County, Virginia USA.

Please answer all four questions below by TICKING, the response that applies to you.

12. *If you answer "Yes" to any question, please attach a signed letter describing the circumstances, and explain the current status of the situation. If medical or psychological, please provide IBLCE with a signed letter from your health care provider stating that the condition is cured or controlled to the extent that it would not impair your ability to practice as a lactation consultant. If you are involved in litigation, please attach a copy of the Complaint. If more information is needed, the IBLCE will confidentially seek further information from you.*

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. In the past ten (10) years, have you been, or are you currently, dependent on alcohol, narcotics, drugs, or any other substances that impair or limit, or if the dependency is left untreated is typically likely to impair or limit in the future, physically or mentally, more than only insignificantly your ability to perform the essential duties (see #3 below for a list) of a health care provider, lactation consultant or breastfeeding counselor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you currently suffer from any severe or chronic illness or disease that specifically impairs or limits, or if left untreated is typically likely to specifically impair or limit, more than only insignificantly your ability to perform any of the essential duties (see #3 below for a list) of a health care provider, lactation consultant or breastfeeding counselor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been convicted of a crime (including minor traffic offences) that is by its nature specifically related to, or of specific importance for the evaluation of, your ability and trustworthiness to perform any of the essential duties of a health care provider, lactation consultant or breastfeeding counselor? These duties include : (1) the duty to preserve client's/patient's confidences; (2) the duty to act with reasonable diligence; (3) the duty to provide competent service; (4) the duty to maintain personal integrity; (5) the duty to report truthfully and fully to the health care system; (6) the duty to uphold the standards of the lactation consultant profession; (7) the duty to exercise independent professional judgment and to avoid conflicts of interest; (8) the duty to follow IBLCE disciplinary determinations; and (9) the duty to promote, protect and support breastfeeding. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been the subject of a substantiated complaint, for which disciplinary or remedial action was taken, including the revocation of any prior business or professional license , related to your actions, advice, performance or non-performance as a health care provider, lactation consultant or breastfeeding counsel, or other actions in the healthcare field (including but not limited to workplace complaints and complaints before an administrative body, licensing board, professional group, court, mediator, arbitrator or other tribunal)? Or are you currently the subject of such a complaint? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature of Applicant _____ **Date** _____

Please read this statement carefully, TICK the appropriate response to each of the four (4) questions above and then sign and date this form.