

**Certified Registered Central Service Technician (CRCST)** certification is designed to recognize individuals who have demonstrated the experience, knowledge, and skills necessary to provide competent services as a central service technician. CRCST's are integral members of the healthcare team who are responsible for decontaminating, inspecting, assembling, disassembling, packaging, and sterilizing reusable surgical instruments or devices in a health care facility that are essential for patient safety.

To earn CRCST certification, candidates are required to successfully demonstrate skills through completion of hands-on work experience as well as successful completion of an examination developed to measure the understanding of general central services and infection prevention topics. CRCST certificants are required to recertify annually through completion of continuing education requirements.

Once your application and payment have been received by IAHCSMM, processing will typically take 2-3 business days. Information on your 90 day exam eligibility period, scheduling your exam, available testing dates and locations, and the testing process will be mailed to the address provided on the application. Please allow an additional 3-5 business days for this information to be delivered by the US Postal Service. You may also request the information be sent to you electronically by providing your email address(es) as indicated in Section One. Email notifications will be sent within 24 hours of application processing. **Scheduling information cannot be given by phone.** Once you receive your scheduling letter/email, it is your responsibility to schedule your exam.

### SECTION ONE – Applicant Information (To be completed by APPLICANT)

Please note: Incomplete or illegible applications can delay processing, clearly print all information

First Name: \_\_\_\_\_ Last Name(s): \_\_\_\_\_  
(As it appears on your primary government issued photo ID) (As it appears on your primary government issued photo ID)

Street Address: \_\_\_\_\_ Apt/Floor/Lot/Unit: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ **USA or Canada**

Current Facility (if employed): \_\_\_\_\_ IAHCSMM ID# \_\_\_\_\_  
(Leave blank if unknown)

Current Position (circle one): Student Technician Supervisor Manager Educator Other: \_\_\_\_\_

Home or Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Home Email: \_\_\_\_\_ (Optional) Work Email: \_\_\_\_\_ (Optional)

**Your exam scheduling information will be mailed to your home address, as listed above, and also emailed, if home and/or work email are provided.**

### SECTION TWO – Payment Information (To be completed by APPLICANT or PAYMENT PROVIDER)

Please note: IAHCSMM cannot accept purchase orders of any kind; **payment must be submitted along with this application**

The examination fee within the United States and Canada is **\$125 USD**. Payment must be submitted, along with this application, in the form of: Credit/Debit Card (US & Canada), Money Order (US & Canada), or Check (US only.) **Payment CANNOT be made by phone.**

- I am submitting a check or money order, made payable to IAHCSMM, by mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601
- I am submitting the credit/debit card information below and give permission for my card to be charged \$125 USD:  
Fax to: 1-312-440-9474, Scan & Email to: certification@iahcsmm.org, or Mail to: 55 West Wacker Dr, Suite 501, Chicago, IL 60601

Credit/Debit Card Holder's Printed Name: \_\_\_\_\_

Credit/Debit Card Number: \_\_\_\_\_ Expiration: \_\_\_\_\_  
(Month/Year)

Credit/Debit Card Holder's Signature: \_\_\_\_\_ CV2#: \_\_\_\_\_

IAHCSMM complies with the Americans with Disabilities Act (ADA) and is interested in ensuring that no disabled individual is deprived of the opportunity to take an examination solely by reason of that disability. IAHCSMM will arrange to provide special testing accommodations for those individuals with a condition or disability as defined under the ADA. Accommodations will be provided at a designated testing center at no additional cost to the applicant. IAHCSMM's "Americans with Disabilities Policy Statement" can be found in full at IAHCSMM.org and in the Certification Handbook. If you believe that you qualify for an accommodation pursuant to the ADA, we ask that you contact IAHCSMM to request a Special Accommodations form, to be completed and submitted with your application.

#### For Office Use Only

S1 \_\_\_\_\_ S2 \_\_\_\_\_ S3 \_\_\_\_\_  
S4 \_\_\_\_\_ S5 \_\_\_\_\_ RT \_\_\_\_\_

Upon passing the CRCST exam, you will be granted one year of complimentary membership with IAHCSSM in addition to your certification. It is not required that you become an IAHCSSM member before taking the exam, nor is it required for you to maintain membership with IAHCSSM in order to be certified. If for any reason you prefer not to receive complimentary membership upon passing your certification exam please indicate so below.

- Yes;** I wish to receive complimentary 1 year IAHCSSM Membership after passing the CRCST exam
- No;** I do not wish to receive complimentary IAHCSSM Membership after passing the CRCST exam

**SECTION THREE – Statement of Understanding (To be completed by APPLICANT)**  
 Please note: Your signature in this section is mandatory in order to test with IAHCSSM

**Statement of Understanding**

I hereby apply to take the CRCST exam. By signing below and submitting an exam application and fee, I attest that I have read and understand the IAHCSSM Certification Handbook (available online at IAHCSSM.org) and agree to abide by the certification program's policies and procedures, and adhere to the Association's code of conduct. I agree to inform IAHCSSM, without delay, of any matter that affects my ability to fulfill the certification requirements.

I further certify that the information provided by and about me on this form (and any other subsequent documentation submitted in relation to my certification) is accurate and correct. I understand that the information I provide to IAHCSSM may be audited for verification. I agree to provide any information necessary to verify my experience and authorize IAHCSSM to make any necessary inquiries in this regard. I understand that providing information on this or any document relating to my certification which is determined to be false or purposefully misleading, or in violation of any portion of the Code of Conduct and/or other policies and procedures, may result in disciplinary action, including the possible denial or revocation of certification, as outlined in the disciplinary policy.

**Release of Exam Results**

I understand that a Pass/Fail notice will be issued at the testing center upon completion of the exam, and that IAHCSSM will only release my full exam results directly to me, in written format, at the home address provided herein. Results are not available orally or electronically, and can take up to two weeks to be delivered. Exam results and pass/fail notifications will not be provided to 3rd parties without my prior express written consent. Upon request IAHCSSM will verify an individual's current certification status (including their certification effective and expiration dates) to any inquiring party, but will not release the details of an individual's examination(s), including exam scores and the number of exam attempts.

**Use of Personal Information**

The information provided to IAHCSSM on this form, and in regard to my certification exam, will be used in accordance of IAHCSSM's Confidentiality Policy, included in the Certification Handbook and available online at IAHCSSM.org. If I request and am granted special testing accommodations IAHCSSM may disclose personal information to third parties as necessary to administer my examination. This may include such information as my disability status, medical condition, or any political, religious, or philosophical beliefs which require accommodation. If IAHCSSM is required by law to disclose confidential information, the individual(s) whose information is released will be notified to the extent permitted by law.

**Non-Disclosure Agreement**

This examination is confidential and proprietary. It is made available to me, the examinee, solely for the purpose of becoming certified in the technical area referenced in the title of this exam. I am expressly prohibited from recording, copying, reproducing, disclosing, publishing, or transmitting this examination, in whole or in part, in any form or by any means, verbal or written, electronic or mechanical, for any purpose.

**Applicant's Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SECTION FOUR – Type of CRCST (To be completed by APPLICANT)**  
 Please sign only ONE of the options below

CRCST certification requires the completion of 400 hours of hands-on experience in a Central Service Department. IAHCSSM strongly recommends that you complete these hours **before** applying to test; by doing so you will be better prepared for your exam and will be granted **Full Certification** upon passing. You do have the option of testing before completing your hours, with the understanding that they must be completed within six months of passing your exam. If you choose to test before the completion of your hours you will be granted **Provisional Certification** upon passing. Please be aware that **IAHCSSM does not provide placement services**; it is your responsibility to find a department in which to complete your hours.

I am applying for **Full Certification**: 400 hours of hands-on experience, as outlined in **SECTION FIVE** of this application, have been completed. Section Five has been completed by the manager/supervisor who witnessed the accumulation of my hours.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OR**

I am applying for **Provisional Certification**: I will complete 400 hours of hands-on experience, on either a paid or volunteer basis, within six months of passing the certification exam. Hours will be accumulated in the specific categories outlined in Section Five of this application. If I fail to complete and submit documentation of these hours to IAHCSSM prior to the end of the 6 month period, my certification will be revoked. Successful completion of a retake exam will then be required to regain certification and full testing fees would apply.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If applying for **Full Certification** please continue on to the next section, the 3rd page of the application must also be completed and submitted.  
 If applying for **Provisional Certification** your application is now complete, the 3rd page of this application does not need to be submitted.

## SECTION FIVE – Hands-On Experience (To be completed by applicant's MANAGER/SUPERVISOR)

Please note: All information in this section must be completed/initialed by the applicant's Manager/Supervisor  
The applicant cannot complete any part of this section

**INSTRUCTIONS:** This section is to be completed by the Manager/Supervisor who oversaw the CRCST applicant's work/volunteer experience. Providing you are in a position above the applicant, this section can be completed by: Lead Techs, Coordinators, Supervisors, Managers, Directors, Chiefs, Administrators, or Hospital-Based Educators/Trainers. By completing this section you attest that the employee/volunteer listed below has completed the minimum 400 hours of hands-on experience required for this IAHCSSM certification and will verify as much if called upon. Every line below must be completed, which includes initialing each area of experience to indicate that it has either been completed or redistributed (but only if such an option is listed.) If hours are redistributed, please indicate as such in the + \_\_\_\_\_ field following the appropriate area(s) of experience.

### Manager/Supervisor Initials

- \_\_\_\_\_ 1. **General Cleaning (32 Hours) + \_\_\_\_\_**  
Instruments – Utensils – Specialty Items, Operation of Mechanical Washers
- \_\_\_\_\_ 2. **Wrapping Packaging (36 Hours) + \_\_\_\_\_**  
Packaging Techniques, Pouches, Flat Wraps, and Rigid Containers; Label/Expiration Dates, etc
- \_\_\_\_\_ 3. **Assemble Instrument/Procedure Trays (60 Hours) + \_\_\_\_\_**  
Assembly/Layout, Inspection, Identification, Use
- \_\_\_\_\_ 4. **Sterilization (64 Hours) + \_\_\_\_\_**  
High & Low Temp Sterilization Processes, Sterilization QA Systems, Record Keeping, Handling/Putting Away Sterile Supplies, Dust Covering
- \_\_\_\_\_ 5. **Storage Clean & Sterile (36 Hours)**  
Rotating Supplies, Inventory and Restocking Carts/Shelves, Outdates, Cleaning Storage Shelves
- \_\_\_\_\_ 6. **Miscellaneous (40 Hours)**  
Quality Assurance Processes, Blood Borne Pathogen Protocols, Soiled Equipment Pick-Up, Standards, Regulations, Policies & Procedures
- \_\_\_\_\_ 7. **Patient Care Equipment (32 Hours)**  
Cleaning – Assembly/Testing Identification, Suction Units, IV Infusion/Patient-Controlled Analgesia Pumps, Hypothermia Units, Hot or Cold Therapy Devices, Infant Incubators, Respirators, Portable Equipment from the OR  
*(Note: If Department does not reprocess PCE, these hours must be added to General Cleaning; initial to the left & indicate above where hours were added)*
- \_\_\_\_\_ 8. **Linen Folding (36 Hours)**  
Inspection, Folding Drapes/Wrappers, Towels, etc.  
*(Note: If Facility does not have any reusable linen, these 36 Hours must be divided in half and added to General Cleaning [18 additional hours] and Assemble Instrument/Procedure Trays [18 additional hours]; initial to the left & indicate above where hours were added)*
- \_\_\_\_\_ 9. **Case Carts (32 Hours)**  
Assembly, Pick Sheets, Cover and Transport to OR  
*(Note: If Facility does not use Case Carts, these 32 Hours must be divided in half and added to Wrapping Packaging [16 additional hours] and Sterilization [16 additional hours]; initial to the left & indicate above where hours were added)*
- \_\_\_\_\_ 10. **Distribution (32 Hours)**  
Par Levels, Point of Use Systems, Exchange Carts, Just-In-Time  
*(Note: If Facility does not use these procedures, these 32 Hours must be divided in half and added to General Cleaning [16 additional hours] and Assemble Instrument/Procedure Trays [16 additional hours]; initial to the left & indicate above where hours were added)*

Following each of the ten areas of experience are several examples of the types of duties which can be used to fulfil the requirement.

Printed Name of Applicant Being Verified: \_\_\_\_\_ IAHCSSM ID#: \_\_\_\_\_  
(Leave blank if unknown)

Facility Where Applicant's Experience Was Obtained: \_\_\_\_\_

Facility Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dates When Applicant's Experience Was Obtained (must have occurred within the past 5 years): \_\_\_\_\_ to \_\_\_\_\_  
Mandatory (Month/Date/Year) Mandatory (Month/Date/Year)

Is the Applicant a Current Employee of the Facility? Yes  No

Printed Name of Manager/Supervisor Verifying Experience: \_\_\_\_\_

Mgr/Spv's Title Within the Department: \_\_\_\_\_ Date: \_\_\_\_\_

Mgr/Spv's Signature: \_\_\_\_\_

Mgr/Spv's Work Phone (with extension): (\_\_\_\_\_) \_\_\_\_\_

Mandatory

Mgr/Spv's Work Email: \_\_\_\_\_

Personal email accounts cannot be used (such as gmail, yahoo, hotmail, etc)

**Please Remember:** The applicant cannot complete any part of this page whatsoever (including their name or facility information.) Doing so will result in the application being returned, unprocessed.