IBLCE: EXAM APPLICATION 2.10

Please read the 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

GIVEN NAMES (IN FULL)																
FAMILY/ SURNAME																

Preferred Title (e.g. Mrs, Ms, Miss, Mr, Dr):______________ **Preferred given Name/Known by:**__________________

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

☐**MALE** ☐**FEMALE**

DATE of BIRTH_ _ / _ _ / _ _
DD MM YY

2. POSTAL ADDRESS:

____

____

____

POST CODE:_____________**COUNTRY:** ______________

PHONE (home):________________________________

PHONE (work):________________________________

MOBILE:_____________________________________

EMAIL:______________________________________

3. EXAM SITE CITY: Write in the name of your exam site city. You may write the name of the town or city, where you would prefer to sit the exam:_________________________/___________________________

My first language is:__________________My primary language is:_____________________________________

The language I wish to sit the exam is:____

4. EXAM FEE: Please pay the full fee that corresponds to the deadline by which your application is postmarked. (See the 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 organization paying:____________________

FORMER IBCLC: L (year lapsed:_______________)

Other years you have been a candidate for the IBLCE Exam 19______ 20______ 20______

5. INDIVIDUAL CONSIDERATIONS:

☐ 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. I understand that I may be asked to submit it, as directed, at least seven days before the exam

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

6. CALCULATION OF BREASTFEEDING COUNSELLING HOURS OVER THE LAST 5 YEARS:

Using the table below, provide self-documentation of your hours of experience providing clinical breastfeeding counselling as described in the Candidate Information Guide

PLACE OF WORK / EXPERIENCE *Column 1*	**TITLE / POSITION** *Column 2*	**AREA / NATURE OF WORK / EXPERIENCE** *Column 3*	**month/year started and ended** *Column 4*	***total weeks excl leave*** *Column 5*	**average hours per week** *Column 6*	**total hours worked** *Column 7*	**% time providing BC** *Column 8*	TOTAL BC HOURS *Column 9*
1. Friendly Hospital Palmerston North	*Nurse/Midwife*	*Mostly postnatal wards, occasionally delivery suite. One-to-one consultations and weekly 1 hr breastfeeding classes.*	*4/99 to 10/04*	*253 wks*	*20 hrs*	*5060 hrs*	*40%*	*2024 hrs*
2. Breastbest Hospital Brisbane QLD	*Midwife Parent Educator*	*BFHI accredited - one-to-one postnatal ward, BF resource person for special care nursery, 8 hrs per week in BF Clinic.*	*8/05 to 8/06*	*46 wks*	*38 hrs*	*1748 hrs*	*60%*	*1049 hrs*

Please mark with an * those hours that are relevant to this supervisor

TOTAL BREASTFEEDING CLINICAL COUNSELLING HOURS:

Name and position of a supervisor who can verify some or all of your clinical practice hours:

____

Supervisor's phone number: ______________________________

MINIMUM CLINICAL HOURS MUST BE COMPLETE AT TIME OF APPLICATION

7. LIST OF PROFESSIONAL LACTATION EDUCATION HOURS COMPLETED AND/OR SIGNED UP FOR:

In the table below, list a minimum of 45 hours of professional lactation/breastfeeding education specific to lactation or breastfeeding management that you have attended, during the last 5 years. Enclose photocopies of your certificates of attendance or other documentation for hours completed. **Make sure that your list totals a minimum 45 hours** [60 hours if you are taking the exam in a translated version]. **Minimum Education** required **MUST** be completed at time of application. For full information see the Candidate Information Guide

DATE	LOCATION	TITLE OF SESSION OR PROGRAM OR COURSE	CERTIFICATE ENCLOSED?	HOURS or L CERPs
15/8/08	*Goode Hospital, Perth*	*Low weight gain in the breastfed baby*	*Yes*	*5.5 hours*
Sept 08	*Hong Kong*	*Lactation and human milk banking*	*Yes*	*32hours*

TOTAL EDUCATION HOURS – COMPLETED AT THE TIME OF APPLICATION
(MINIMUM 45 Hours or 60 if you are taking the exam in a translated version): ______

MINIMUM EDUCATION REQUIREMENTS MUST BE COMPLETED AT TIME OF APPLICATION

8.PRINCIPLE EMPLOYMENT SETTING:

- ☐ Hospital - maternity (all areas)
- ☐ Hospital - postnatal only
- ☐ Hospital - general
- ☐ Hospital - paediatric
- ☐ Hospital - NICU / SCN
- ☐ Maternal & child health
- ☐ Health visitor
- ☐ Clinic / community setting
- ☐ Postnatal domiciliary
- ☐ Birthing centre / home births
- ☐ Medical practice
- ☐ Private practice
- ☐ Mother support group
- ☐ Educational institution
- ☐ Independent educator

☐ 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:

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

Please tick **one** only of the following:

- ☐ Doctoral Degree in
- ☐ Graduate Diploma in
- ☐ Master's Degree in
- ☐ Tertiary Diploma/Registration e.g. RN or RM
- ☐ Bachelor Degree in
- ☐ 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 to sit for the IBLCE Certification Examination for lactation consultants. 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 exam 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 examination, 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 appropriate box.
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.

12: SIGNED STATEMENT

	Question	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?	☐	☐
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?	☐	☐
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.	☐	☐
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?	☐	☐

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 application.