

Certified Central Service Vendor Partner (CCSVP) Exam

Form Valid March 1, 2023 – February 29, 2024



Certified Central Service Vendor Partner (CCSVP) certification is designed to recognize vendors who have demonstrated knowledge of Sterile Processing concepts and processes including the decontamination, inspection, assembly, packaging, and sterilization of reusable surgical instruments.

To earn CCSVP certification, candidates are required to successfully demonstrate knowledge through the completion of an online course, specific Sterile Processing department observations, and successful completion of an examination developed to measure the understanding of general sterile processing and infection prevention topics. CCSVP are required to recertify annually through completion of continuing education requirements.

Please read and complete each section fully and accurately in clear, legible handwriting or type. The completed application and full payment must be received for processing.

Submitted applications will be processed in approximately three to four weeks. By submitting, you agree to a \$25 non-refundable processing fee. Information on how to schedule your exam, as well as your window of eligibility, will be sent to the email provided. (Scheduling information cannot be provided by phone.) Once your application is approved, it is your responsibility to schedule your exam within the 120-day window provided.

Additional information on certification requirements, policies, and procedures is available in the HSPA Handbook and at myhspa.org/certification. For further assistance, contact HSPA at 312.440.0078 or certification@myhspa.org.

Please complete each page and mail, fax, or email your completed application to:

Mail: **HSPA**
55 West Wacker Drive, Suite 501
Chicago, IL 60601

Fax: **312.440.9474**
Email: **certification@myhspa.org**

APPLICATION CHECKLIST

I am ready to sit for the CCSVP exam within the next 4 months, once my application is approved.

Section 1: Applicant Information

I have completed the applicant information and am employed as a vendor by a Sterile Processing-related products or services company, and have completed the HSPA online Central Service Vendor Partner education course.

Section 2: Standards of Conduct, Disclosure, and Attestations

I have signed and dated the Statement of Understanding.

HSPA 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. HSPA 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.

HSPA's "Americans with Disabilities Policy Statement" can be found in full at myhspa.org and in the Certification Handbook. If you believe that you qualify for an accommodation pursuant to the ADA, we ask that you contact HSPA to request a Special Accommodations form, to be completed and submitted with your application.

Section 3: Application Fee

I have included a signed check/money order or credit card information with the application.

Section 4A: Clinical Observation

My **Manager/Supervisor** has completed and signed the clinical observation.

Section 4B: Clinical Observation

My **Manager/Supervisor** has completed and signed the clinical observation.

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SECTION 1: **APPLICANT INFORMATION**

Please enter your first and last name as they appear on your primary government issued photo ID.

Mr. Mrs. Ms. Dr.

Applicant First Name: _____

Applicant Last Name(s): _____

HSPA ID# (Optional): _____

Personal Information

Home Address: _____ Apt/Floor/Unit: _____

City, State/Province, Zip/Postal Code: _____

Country (if outside the USA): _____

Home Telephone: _____ Personal Email: _____

Employment Information (you must be employed as a vendor in order to be eligible for CCSVP certification)

Organization Name: _____

Current Position Title: _____

Business City and State/Province: _____

Country (if outside the USA): _____

Business Telephone: _____ Business Email: _____

An email is required. Confirmation and scheduling information will be sent by email. Please check which email you would like to be used for correspondence: personal business

Please check which address you would like to be used for any mailed correspondence: personal business

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SECTION 2: STANDARDS OF CONDUCT, DISCLOSURE AND ATTESTATIONS

APPLICATION STATEMENT OF UNDERSTANDING

I hereby apply to take the CCSVP exam. By signing below and submitting an exam application and fee, I attest that I have read and understand the HSPA Certification Handbook (available online at myhspa.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 HSPA, 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 HSPA may be audited for verification. I agree to provide any information necessary to verify my experience and authorize HSPA 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 I will receive an individual score report containing a notification of "pass" or "fail" for the overall examination on screen at the testing center upon completion of the exam, and that HSPA will only release my pass/fail results directly to me, in written format, at the preferred address provided herein. Pass/fail notifications will not be provided to 3rd parties without my prior express written consent. Upon request, HSPA 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 HSPA on this form, and in regard to my certification exam, will be used in accordance with HSPA's Confidentiality Policy, included in the Certification Handbook and available online at myhspa.org. If I request and am granted special testing accommodations, HSPA 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 HSPA 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.

Printed Name: _____

Signature (must be handwritten): _____

Date: _____

SECTION 3: APPLICATION FEE IS \$140 USD

One attempt at the exam is included in the cost of the CCSVP course. If this is your first time taking the exam, this section should be left blank. We cannot accept purchase orders or payments by phone. The application fee includes the cost to take the exam one time, as well as a \$25 non-refundable processing fee. Subsequent examinations and testing are subject to additional testing fees.

Check or Money Order enclosed (payable to HSPA) VISA MasterCard American Express Discover

Cardholder Name: _____

Credit Card Number: _____

CVV (found on back of card): _____

Expiration Date: _____

Zip Code of Billing Address: _____

Signature (must be handwritten): _____

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TO BE COMPLETED IN FULL BY THE MANAGER/SUPERVISOR OF A SP DEPARTMENT

SECTION 4A: CLINICAL OBSERVATION

All information on this page must be completed in full by the **Manager/Supervisor** who oversaw the applicant's work/volunteer experience. **If the applicant completes any portion of this page, the application will be rejected.**

- Two separate clinical observation rounds in two separate SP facilities must be completed.
- The information must be verified by a person in a position higher than the applicant (Lead Tech, Coordinator, Supervisor, Manager, Director, Chief, Administrator or Hospital-Based Educator/Trainer).
- Manager/Supervisor must provide work contact information. No personal contact information will be accepted.

Printed Name of Manager/Supervisor: _____

Current Position Title of Manager/Supervisor: _____

Select one: Lead Tech Coordinator Supervisor Manager Director Chief Administrator Other _____
DESCRIBE

Work Phone (with extension): _____ Work Email: _____

I attest that the applicant listed below has completed the observation component required for the Certified Central Service Vendor Partner (CCSVP) certification. I further understand that I may be called upon to verify this information in further detail.

Signature (must be handwritten): _____ Date: _____

Printed Name of Applicant: _____

Dates of Experience: from (month/date/year) ___/___/___ to (month/date/year) ___/___/___ *must have occurred within the past 5 years

Name of Facility Where Experience Was Obtained: _____

Facility Address: _____

City, State/Province, Zip/Postal Code: _____

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

PLEASE INITIAL EACH AREA OF EXPERIENCE COMPLETED BELOW (Typed Initials will Not Be Accepted):

INITIAL **1. Decontamination (5 Hours)**
Manual Cleaning Processes, Mechanical Cleaning Processes, and Disinfection

INITIAL **2. Inspection, Assembly and Packaging (5 Hours)**
Instrument Inspection, Testing and Assembly, and Packaging Methods

INITIAL **3. Sterilization (4 Hours)**
High and Low Temperature Sterilization and Sterility Assurance Systems

INITIAL **4. Sterile Storage and Distribution Systems (2 Hours)**
Sterile Storage, Inventory Management, and Distribution Systems

PLEASE REMEMBER: Every line in this section must be completed, and the applicant cannot complete any part of this section, (not even their name or facility information.) Doing so may result in the application being returned, unprocessed.

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TO BE COMPLETED IN FULL BY THE MANAGER/SUPERVISOR OF A SP DEPARTMENT

SECTION 4B: CLINICAL OBSERVATION

All information on this page must be completed in full by the **Manager/Supervisor** who oversaw the applicant's work/volunteer experience. **If the applicant completes any portion of this page, the application will be rejected.**

- Two separate clinical observation rounds in two separate SP facilities must be completed.
- The information must be verified by a person in a position higher than the applicant (Lead Tech, Coordinator, Supervisor, Manager, Director, Chief, Administrator or Hospital-Based Educator/Trainer).
- Manager/Supervisor must provide work contact information. No personal contact information will be accepted.

Printed Name of Manager/Supervisor: _____

Current Position Title of Manager/Supervisor: _____

Select one: Lead Tech Coordinator Supervisor Manager Director Chief Administrator Other _____ DESCRIBE

Work Phone (with extension): _____ Work Email: _____

I attest that the applicant listed below has completed the observation component required for the Certified Central Service Vendor Partner (CCSVP) certification. I further understand that I may be called upon to verify this information in further detail.

Signature (must be handwritten): _____ Date: _____

Printed Name of Applicant: _____

Dates of Experience: from (month/date/year) ___/___/___ to (month/date/year) ___/___/___ *must have occurred within the past 5 years

Name of Facility Where Experience Was Obtained: _____

Facility Address: _____

City, State/Province, Zip/Postal Code: _____

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

PLEASE INITIAL EACH AREA OF EXPERIENCE COMPLETED BELOW (Typed Initials will Not Be Accepted):

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