

Advanced Oncology Certified Nurse Practitioner (AOCNP®)
Candidate Practice Verification Form
AOCNP® candidates only (AOCNS® candidates use other side)

- If applying by mail or fax, this form **must be** submitted with the Certification Application Form. If applying online, you will be prompted to enter the information requested below.
- Individuals providing verification of supervised practice may be contacted by ONCC during a random application audit.
- This form must provide verification of a minimum of 500 **total** hours of supervised practice as an oncology nurse practitioner (indicate in either Part A, Part B, or both). Please photocopy this form if you need to provide verification by more than one individual per section.

Part A: Supervised Practice Completed Within the Educational Program

I, the undersigned, verify that _____ (*print full name of AOCNP® candidate*) has completed _____ hours of supervised practice as an oncology nurse practitioner **within the educational program**.

The supervised practice was completed between the dates of _____ (*insert start and end dates of supervised practice*).

Please check your role:

- | | |
|--|--------------------------------------|
| <input type="radio"/> Physician Preceptor | <input type="radio"/> Faculty member |
| <input type="radio"/> Nurse Practitioner Preceptor | <input type="radio"/> Other _____ |
- (please specify role)*

Name (print name) _____

Title _____

Name of Unit (if applicable) _____

Name of Institution _____

Address _____

Daytime Telephone Number (with area code) _____

Signature _____ Date _____

Part B: Supervised Practice Following Graduation from the Educational Program

I, the undersigned, verify that _____ (*print full name of AOCNP® candidate*) has completed _____ hours of supervised practice as an oncology nurse practitioner **following graduation from the nurse practitioner program**. The supervised practice was completed between _____ (*insert start and end dates of supervised practice*).

The supervised practice was completed between _____ (*insert start and end dates of supervised practice*).

Please check your role:

- | | |
|---|---|
| <input type="radio"/> Supervisor | <input type="radio"/> Collaborating Advanced Practice Nurse |
| <input type="radio"/> Collaborating Physician | <input type="radio"/> Other _____ |
- (please specify role)*

Name (print name) _____

Title _____

Name of Unit (if applicable) _____

Name of Institution _____

Address _____

Daytime Telephone Number (with area code) _____

Signature _____ Date _____