



# 2008 AOCNP® & AOCNS® Certification Test Application

Please read the instructions on page 26 of the 2008 Oncology Nursing Certification Test Bulletin. Complete all the information requested. Please print. Illegible, incomplete, or unsigned applications will be returned.

Last Name (please use name as it appears on your photo ID) \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

(Area Code) Work Phone Number \_\_\_\_\_ (Area Code) Home Phone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

1. Have you previously taken an ONCC test?  Yes (indicate the test and month/year taken)  No (go to #3)

OCN® \_\_\_\_\_  CPON® \_\_\_\_\_  AOCN® \_\_\_\_\_  AOCNP® \_\_\_\_\_  AOCNS® \_\_\_\_\_  
mol/yr mol/yr mol/yr mol/yr mol/yr

2. What was your name at the time you tested? \_\_\_\_\_

3. Indicate if you are a current member of either of the following organizations:

Oncology Nursing Society  
 Assoc. of Pediatric Hematology/Oncology Nurses \_\_\_\_\_ Member/Customer ID Number \_\_\_\_\_

4. Which test are you taking?  AOCNP®  AOCNS®

5. Required Documentation - Candidates must enclose the following with the application form:

AOCNS®: Month/year Master's or higher degree in nursing was earned: \_\_\_\_\_

Transcript showing your name, conferral date, and degree earned  
 AOCNS® Candidate Practice Verification Form (page 29)

AOCNP®: Month/year Master's or higher degree in nursing was earned: \_\_\_\_\_

Month/year accredited Nurse Practitioner Program completed: \_\_\_\_\_  
 Transcript showing your name, conferral date, and degree earned  
 Transcript showing your name, conferral date, and completion of NP Program  
 AOCNP® Candidate Practice Verification Form (page 30)

6. Do you require Special Testing Accommodations due to a disability?  No  Yes (see page 17)

## 7. Demographic & Employment Information (required)

### Highest Nursing Degree (select one)

- Master's  
 Doctorate

### Employment Status (select one)

- Full-time  
 Part-time  
 Retired  
 Unemployed

### Primary Functional Area (select one)

- Administration  
 Education  
 Patient Care  
 Research  
 Other

### Primary Patient Setting (select one)

- Adult  
 Adult & Pediatric  
 Pediatric

### Primary Position (select one)

- Academic Educator  
 Case Manager  
 Clinical Nurse Specialist  
 Clinical Trials Nurse  
 Consultant  
 Director/Manager/Coordinator  
 Genetic Counselor  
 Medical Science Liaison  
 Nurse Practitioner  
 Nurse Scientist  
 Patient Educator  
 Pharmaceutical Representative  
 Staff Educator  
 Staff Nurse  
 VP/CNO  
 Other

### Primary Specialty (select one)

- Blood & Marrow Transplantation  
 Medical Oncology  
 Palliative Care  
 Prevention/Detection  
 Radiation Oncology  
 Surgical Oncology  
 Other

### Primary Work Setting (select one)

#### Inpatient

- Blood & Marrow Transplant Unit  
 Intensive Care Unit  
 Medical Unit - General  
 Medical Unit - Oncology  
 Surgical Unit - General  
 Surgical Unit - Oncology  
 Other

#### Outpatient

- Home Care  
 Hospice  
 Hospital-based Clinic  
 Physician Office/Infusion Center  
 Radiation-Free Standing  
 Radiation-Hospital-based  
 Other

#### Other

- Corporate/Industry  
 Extended Care Facility  
 HMO/Managed Care  
 School of Nursing  
 Self-Employed

### Who is paying for your certification? (select one)

- I am paying with my own funds  
 My employer is paying  
 I will be reimbursed by my employer upon successful certification  
 I am an ONCC award winner

Please complete other side of form

**8. Biographical Data** *(optional)*

**Race**

- American Indian/Alaskan Native
- Asian
- Black/African American
- Caucasian/White
- Mixed Race
- Native Hawaiian/Other Pacific Islander
- Other Race
- Do not care to respond

**Are you Hispanic/Latino?**

- Yes
- No

**Sex**

- Female
- Male

**9. Do you hold any other nursing certifications?**  No  Yes

If yes, please list credentials \_\_\_\_\_

**10. Nursing License Information**

*(Required. Complete below and enclose a photocopy of your license.)*

Nursing License Number \_\_\_\_\_

State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Month/Year you became a Registered Nurse \_\_\_\_\_

**11. Affirmation** *(required)*

**Fee & Payment Information**

**12. Check the certification test, and fee you are paying. Indicate payment type.**

<p><b>Computer-based tests - offered year-round</b></p> <p><input type="checkbox"/> AOCNP® <input type="checkbox"/> AOCNS®</p> <p style="text-align: center;"><b>ONS/APHON Member</b></p> <p style="text-align: center;"><b>Nonmember</b></p>	<p>Allow 4-6 weeks to receive your Authorization to Test</p> <p><input type="checkbox"/> \$ 260</p> <p><input type="checkbox"/> \$ 380</p>
<p><b>International Test Site Fee</b>—Additional fee for candidates testing outside North America</p>	<p><input type="checkbox"/> \$ 75</p> <p><i>International test candidates must apply by mail or fax</i></p>

*\* Discount applies to complete applications only. Incomplete applications (including those without required documentation) will be charged the full fee. All complete applications must be received by the final deadline, regardless of postmark.*

Check Enclosed *(payable to the Oncology Nursing Certification Corporation)*

Visa  MasterCard  American Express  Discover

\_\_\_\_\_  
Cardholder's Name Signature

\_\_\_\_\_  
Card number Expiration Date

**Name (print)**

**Signature**

**Date**

By signing and submitting this application form, I accept the conditions set forth in the 2008 Oncology Nursing Certification Test Bulletin concerning the administration of the examination, the reporting of examination scores, and certification policies. I certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is given in good faith. I further understand that if any information is later determined to be false, the Oncology Nursing Certification Corporation reserves the right to sanction any certification that has been granted on the basis thereof. The Oncology Nursing Certification Corporation will randomly select a number of applications to audit for validity.

**Did you remember to:**

- complete all sections of the application?
- enclose your transcript(s)?
- include the completed AOCNP® or AOCNS® Candidate Practice Verification Form
- include payment (check, money order, or credit card information). If your employer is funding your registration, please obtain the check from your employer and include it with your application.