

Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
Candidate Practice Verification Form
AOCNS® candidates only

- If applying by mail or fax, this form **must be** submitted with the certification Test 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 adult oncology advanced practice nurse (indicate in either Part A, Part B, or both). Please photocopy this form if you need to provide verification by more than one individual in either section.

Part A: Supervised Practice Completed Within the Graduate Educational Program

I, the undersigned, verify that _____ (print full name of AOCNS® candidate) has completed _____ hours of supervised practice in an advanced practice role in adult oncology nursing **within the graduate 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"/> Advanced Practice Nurse 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 AOCNS® candidate) has completed _____ hours of supervised practice in an advanced practice role in adult oncology nursing **following graduation from 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"/> 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 _____