

2011 OCN® - CPHON® - CBCN® Certification Test Application

Please read the instructions on page 26 of the 2011 Oncology Nursing Certification Test Bulletin. Complete all the information requested. Please print. Illegible, incomplete, or unsigned applications will not be accepted.

Last Name (list your last and first name as it appears on your photo ID) First Name Middle Initial

Home Address

City State Zip/Postal Code Country

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

E-mail Address (list an individual or personal email address, not a group mailbox that is shared in the workplace)

1. Have you previously taken an ONCC test? Yes (indicate the most recent test and month/year taken) No (go to #3)
 OCN® CPON® CPHON® AOCN® AOCNP® AOCNS® CBCN® _____ mm/yy last test taken
2. What was your name at the time you most recently 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. Are you applying for: Initial certification - Candidates who are not renewing current certification (go to #6)
 Certification Renewal Option 2 or Option 3 - OCN®s due to renew in 2011 only (go to #5)
5. Are you renewing by: Option 2: Test + Practice hours (go to #6)
 Option 3: Test + ONC-PRO (OCN® Only) (indicate the number of ONC-PRO points below, continue to #6)
_____ OCN® (100 required)

Test Information

6. Which test are you taking? OCN® CPHON® CBCN®
7. Documentation—Initial candidates (those not renewing current certification) must enclose documentation they have completed the required continuing education or an academic elective (see pages 4, 7 or 10). Indicate you have enclosed:
OCN® or CPHON®: 10 contact hours of nursing CE in oncology or academic elective in oncology
CBCN®: 10 contact hours of nursing CE in breast care
8. What date will you be taking the test? (See page 2 for application deadlines)
 February 2011 May 2011 August 2011 November 2011
9. Do you require Special Testing Accommodations due to a disability? No Yes (submit form on page 35)

10. Demographic & Employment Information (required)**Highest Nursing Degree (select one)**

- Diploma
 Associate
 Bachelor's
 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 Population (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
 Navigator
 Nurse Practitioner
 Nurse Scientist
 Patient Educator
 Pharmaceutical Representative
 Staff Educator
 Staff Nurse/Nurse Clinician
 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
 Other

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

11. Biographical Data (optional)

- Race American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander Other Race Do not care to respond
- Are you Hispanic/Latino? Yes No
- Sex Female Male
- Asian Black/African American Caucasian/White Mixed Race

12. Do you hold any other nursing certifications? No Yes _____
 please list credentials

13. 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 _____

14. Nursing Experience

All candidates: Total months of experience as an RN in the past 36 months (3 yrs.): _____ months

OCN® candidates: Total hours of experience in adult oncology in the past 2 1/2 years: _____ hrs

CPHON® candidates: Total hours experience in pediatric oncology/hematology in the past 2 1/2 years: _____ hrs

CBCN® candidates: Total hours of experience in breast care in the past 2 1/2 years: _____ hrs

15. Verification Information (required) - Print the name, title, institution, and phone number of a supervisor who can verify your most recent work experience. Do not list yourself in this space.

Name _____ Title _____
 Institution _____ Phone _____

16. Nursing Experience Details (required)

List below, starting with most recent, your RN experience for the past three years. Include the start and end dates for each position, name and city/state of your employer(s), position title, number of hours you worked per week during that time, and the percentage of your time spent in adult oncology, pediatric oncology/hematology or breast care.

| From (mm/dd/yy) | To (mm/dd/yy) | Name and City/State of Employer | Position Title | # Hours worked per week | % of Time in adult oncology, pediatric hematology/oncology, or breast care |
|-----------------|---------------|---------------------------------|----------------|-------------------------|--|
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17. Affirmation (required)

Name (print) _____ Signature _____ Date _____

By signing and submitting this application form, I confirm I have read, understand and accept the conditions set forth in the 2011 Oncology Nursing Certification Test Bulletin concerning the administration of the examination, the reporting of examination scores, and certification policies. I certify that I have met the eligibility criteria, and 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.

18. Fee & Payment Information - The fees below apply to paper applications submitted by mail or fax. To save \$25, apply online at www.oncc.org. Check the certification method and fee you are paying. Reduced fees apply to candidates age 65 or older at the time of application (proof of age may be required).

| | Early Bird Deadline (\$100 savings included) | Final Deadline (Full Fee) |
|--|--|--|
| Test Candidates <input type="radio"/> OCN® <input type="radio"/> CPHON® <input type="radio"/> CBCN® <input type="radio"/> February 1-28, 2011 <input type="radio"/> May 2-31, 2011 <input type="radio"/> August 1-31, 2011 <input type="radio"/> November 1-30, 2011 ONS/APHON Member <input type="radio"/> \$ 290 <input type="radio"/> \$ 390 Nonmember <input type="radio"/> \$ 410 <input type="radio"/> \$ 510 ONS/APHON Member: Age 65 or older <input type="radio"/> \$ 224 <input type="radio"/> \$ 324 Nonmember: Age 65 or older <input type="radio"/> \$ 314 <input type="radio"/> \$ 414 | October 20, 2010 January 5, 2011 April 6, 2011 July 6, 2011 | N/A January 19, 2011 April 20, 2011 July 20, 2011 |
| Are you testing outside North America? Available in November 2011 only Add \$75 | <input type="radio"/> \$ 75 | <input type="radio"/> \$ 75 |
| Renewal Option 3: Test + ONC-PRO <input type="radio"/> OCN® ONS/APHON Member <input type="radio"/> \$ 390 <input type="radio"/> \$ 490 Nonmember <input type="radio"/> \$ 510 <input type="radio"/> \$ 610 ONS/APHON Member: 65 or older <input type="radio"/> \$ 292 <input type="radio"/> \$ 392 Nonmember: Age 65 or older <input type="radio"/> \$ 383 <input type="radio"/> \$ 483 | See test deadlines, above | See test deadlines, above |

- Check enclosed (payable to the Oncology Nursing Certification Corporation)
 Visa MasterCard American Express Discover

Cardholder's Name _____ Signature _____

Card Number _____ Expiration Date _____