

Certification Renewal Application - Option 3 (Test + ILNA)

Please read the information in the *ONCC Certification Manual*. Complete all 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 shared in the workplace)

/ /

Birthday

1. Which credential are you renewing?

OCN® CPHON® AOCNP® CBCN® BMTCN® _____ mm/yy last test taken

2. What was your name at the time you most recently tested/renewed? _____

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

Oncology Nursing Society

Association of Pediatric Hematology/Oncology Nurses

Member/Customer ID Number

4. Are you applying for: Option 3: Test + ILNA

TEST INFORMATION

5. Do you require Special Testing Accommodations due to a disability?

No Yes (submit Special Accommodations Request Form)

EXPERIENCE

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

7. **Nursing License Information** (required)

Nursing License Number _____ State _____

Expiration Date _____ Month/Year you became a Registered Nurse _____

8. **Nursing Experience** (required)

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

Total hours in oncology in the past 2 1/2 years: _____ hours

9. **Verification Information** - Print the name, title, institution, and phone number of a supervisor who can verify your most recent work experience. Do not list yourself.

Name Title

Institution Phone

10 **Nursing Experience Details** - List below, starting with most recent, your RN experience for the past 3 years. Include start & end dates for each position, title, name and city/state of your employer(s), number of hours you worked per week during that time, and the percentage of your time spent in adult oncology. Attach additional copies of this page if needed.

From: ___ / ___ / ___ To: ___ / ___ / ___ Title: _____
 Employer: _____ City, State _____
 Number hours worked per week _____ % of time spent in oncology: _____

From: ___ / ___ / ___ To: ___ / ___ / ___ Title: _____
 Employer: _____ City, State _____
 Number hours worked per week: _____ % of time spent in oncology: _____

From: ___ / ___ / ___ To: ___ / ___ / ___ Title: _____
 Employer: _____ City, State _____
 Number hours worked per week _____ % of time spent in oncology: _____

11. Biographical Data (OPTIONAL)

Race	What is your age range?	What is your salary range?
American Indian/Alaskan Native	20-24 years	Less than \$20,000
Asian	25-29 years	\$20,000-\$29,999
Black/African American	30-34 years	\$30,000-\$39,999
Caucasian/White	35-39 years	\$40,000-\$49,999
Mixed Race	40-44 years	\$50,000-\$59,999
Native Hawaiian/Other Pacific Islander	45-49 years	\$60,000-\$69,999
Other Race	50-54 years	\$70,000-\$79,999
Do not care to respond	55-59 years	\$80,000-\$89,999
	60-64 years	\$90,000-\$99,999
Are you Hispanic/Latino?	65-69 years	\$100,000-\$109,999
Yes No	Over 69 years	\$110,000-\$119,999
		\$120,000 and up
Sex		
Female Male		

12. Demographic & Employment Information (REQUIRED)

Highest Nursing Degree (select one)	Primary Position (select one)	Primary Specialty (select one)
Associate	Academic Educator	Blood & Marrow Transplantation
Bachelor's	Care Coordinator	End of Life Care
Diploma	Case Manager	Hematology
DNP	Clinical Nurse Specialist	Home Care
Master's	Clinical Trials Nurse	Hospice
PhD/DNSc	Consultant	Intensive Care
Other	Executive	Medical Oncology
	Genetics Counselor	Medical-Surgical Oncology
Employment Status (select one)	Manager/Coordinator/Director	Non-Oncology (choose below)
Full-time	Medical Science Liaison	Palliative Care
Part-time	Nurse Informaticist	Prevention/Detection
Retired	Nurse Navigator	Radiation Oncology
Unemployed	Nurse Practitioner	Surgical Oncology
	Nurse Scientist	Survivorship
Primary Functional Area (select one)	Patient Educator	N/A
Administration	Pharmaceutical Representative	Non-Oncology Specialty (select one)
Consultation	Quality Improvement Nurse/Coordinator	*Required if Non-Oncology Specialty selected as Primary Specialty
Education	Staff Educator	Cardiac Care
Patient Care	Staff Nurse	Chronic Care
Research	Student	Critical Care
Other	Vice President/Chief Nursing Officer	Dermatology
	Other	Emergency/Urgent Care
Primary Patient Population (select one)		Gastrointestinal
Adult		General Medical-Surgical
Adult & Pediatric	Primary Work Setting (select one)	Geriatrics
Pediatric	Academic Institution	Gynecology
N/A	Extended Care Facility	Infectious/Communicable Disease
	Government Agency	Infusion Services
Who is paying for your test?	Healthcare Industry	Neurology
I am an award winner	Home Care	Occupational Health
I am paying with my own funds.	Hospice	Prevention/Detection
I will be reimbursed by my employer upon successful certification.	Hospital Setting (Ambulatory)	Primary Care
My employer	Hospital Setting (Inpatient)	Psychiatric/Mental Health
	Physician Practice	Pulmonary
	Professional Association	Radiology
	Survivorship Clinic	Renal/Dialysis
	Other	Solid Organ Transplant
		Urology
		Other

13. Fee & Payment - Check the 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)
Renewal Option 3: Test + ILNA	September 15	October 15
ONS/APHON Member	<input type="radio"/> \$ 396	<input type="radio"/> \$ 496
Nonmember	<input type="radio"/> \$ 516	<input type="radio"/> \$ 616

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

Cardholder's Name	Signature
Card Number	Expiration Date

14. Affirmation (required)

By signing and submitting this application form, I confirm I have read, understand, and accept the conditions set forth in the *ONCC Registration Manual* and on the ONCC website concerning the administration of the examination, the reporting of examination scores, and certification policies, including confidentiality of ONCC examinations. I confirm that my RN license (including APRN license) is not subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit my practice in any way. I agree that I will notify ONCC in writing within 30 days of any restriction placed on my RN license (including APRN license). I confirm that I have no criminal convictions, including indictment, arrest, conviction or plea of guilty to any felony within the past 3 years, or limitation, sanction, revocation or suspension by a healthcare organization, professional organization, or other private or governmental body relating to nursing or public health safety. I confirm that the information I provide in the application is true, complete and correct to the best of my knowledge and is given in good faith. I confirm that I understand that if any information is later determined to be false, the ONCC reserves the right to sanction any certification that has been granted on the basis thereof.

Name (print)	Signature	Date
--------------	-----------	------

Application Submission Instructions

Submit this application with full payment. Applications, documentation and payment must be received by the application deadline date.

By overnight or other guaranteed delivery method (recommended):

Dollar Bank
 ONCC Lockbox
 2700 Liberty Avenue
 Pittsburgh, PA 15222
 Phone: (412) 859-6104

By regular mail (allow several weeks for delivery). Do not use this address for overnight or other guaranteed delivery methods:

Oncology Nursing Certification Corporation
 P.O. Box 3445
 Pittsburgh, PA 15230-3445

By Fax:

(412) 859-6168