Certification Renewal Application - Option 3 (Test + ILNA)

Please read the information in the ONCC Test Registration Manual and Renewal Manual. Complete all information requested. Please print. Illegible, incomplete, or unsigned applications will not be accepted.

1. Which credential are you renewing?
   - OCN®
   - CPHON®
   - AOCNP
   - CBCN®
   - BMTCN®

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

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

5. Do you require Special Testing Accommodations due to a disability?  
   - No
   - Yes (submit Special Accommodations Request Form)

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  

continued on next page
10 Nursing Experience Details - List below, starting with most recent, your RN experience for the past 3 years (36 months). 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 the specialty (i.e., adult oncology for OCN, AOCNP; pediatric hematology oncology for CPHON; breast care for CBCN; blood and marrow transplantation for BMTCN). 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  
- 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

What is your salary range?  
- Less than $20,000  
- $20,000-$29,999  
- $30,000-$39,999  
- $40,000-$49,999  
- $50,000-$59,999  
- $60,000-$69,999  
- $70,000-$79,999  
- $80,000-$89,999  
- $90,000-$99,999  
- $100,000-$109,999  
- $110,000-$119,999  
- $120,000 and up

Who is paying for your test?  
- I am an award winner  
- I am paying with my own funds.  
- I will be reimbursed by my employer upon successful certification.  
- My employer

12. Demographic & Employment Information (REQUIRED)
Highest Nursing Degree (select one)  
- Associate  
- Bachelor's  
- Diploma  
- DNP  
- Master's  
- PhD/DNSc  
- Other

Primary Position (select one)  
- Academic Educator  
- Care Coordinator  
- Case Manager  
- Clinical Nurse Specialist  
- Clinical Trials Nurse  
- Consultant  
- Executive  
- Genetics Counselor  
- Manager/Coordinator/Director  
- Medical Science Liaison  
- Nurse Informaticist  
- Nurse Navigator  
- Nurse Practitioner  
- Nurse Scientist  
- Nurse Practitioner  
- Patient Educator  
- Pharmaceutical Representative  
- Quality Improvement Nurse/Coordinator  
- Staff Educator  
- Staff Nurse  
- Student  
- Vice President/Chief Nursing Officer  
- Other

Primary Functional Area (select one)  
- Administration  
- Consultation  
- Education  
- Patient Care  
- Research  
- Other

Primary Patient Population (select one)  
- Adult  
- Adult & Pediatric  
- Pediatric  
- N/A

Primary Specialty (select one)  
- Blood & Marrow Transplantation  
- End of Life Care  
- Hematology  
- Home Care  
- Hospice  
- Intensive Care  
- Medical Oncology  
- Medical-Surgical Oncology  
- Non-Oncology (choose below)  
- Palliative Care  
- Prevention/Detection  
- Radiation Oncology  
- Surgical Oncology  
- Survivorship  
- N/A  
- Non-Oncology Specialty (select one)  
- *Required if Non-Oncology Specialty selected as Primary Specialty  
- Cardiac Care  
- Chronic Care  
- Critical Care  
- Dermatology  
- Emergency/Urgent Care  
- Gastrointestinal  
- General Medical-Surgical  
- Geriatrics  
- Gynecology  
- Infectious/Communicable Disease  
- Intensive Care (ICU)  
- Intensive Care (PACU)  
- Infusion Services  
- Intensive Care (NICU)  
- Intensive Care (SICU)  
- Intensive Care (Step-Down)  
- Intensive Care (Trauma)  
- Neurology  
- Occupational Health  
- Otolaryngology  
- Ophthalmology  
- Orthopedic  
- Obstetrics/Gynecology  
- Physical Medicine & Rehabilitation  
- Plastic Surgery  
- Pulmonary  
- Podiatry  
- Preventive Medicine  
- Psychiatry/Mental Health  
- Radiology  
- Renal/Dialysis  
- Solid Organ Transplant  
- Urology  
- Other

Primary Work Setting (select one)  
- Academic Institution  
- Extended Care Facility  
- Government Agency  
- Healthcare Industry  
- Home Care  
- Hospice  
- Hospital Setting (Ambulatory)  
- Hospital Setting (Inpatient)  
- Physician Practice  
- Professional Association  
- Survivorship Clinic  
- Other

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13. Fee & Payment - Check the fee you are paying.

<table>
<thead>
<tr>
<th>Renewal Option 3: Test + ILNA</th>
<th>Early Bird Deadline</th>
<th>Final Deadline</th>
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<tbody>
<tr>
<td>ONS/APHON Member</td>
<td>September 15</td>
<td>October 15</td>
</tr>
<tr>
<td>Nonmember</td>
<td>$ 400</td>
<td>$ 500</td>
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<tr>
<td></td>
<td>$ 520</td>
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☐ 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 Test 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.