Advanced Oncology Certified Nurse Practitioner (AOCNP®)
Candidate Practice Verification Form
Initial AOCNP® Eligibility Pathway 1 Candidates Only

- If applying for initial AOCNP® certification by Pathway 1, this form must be submitted with the certification 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 nurse practitioner (indicate in either Part A, Part B, or both). Please photocopy this form if you need to provide verification by more than one individual per section.

**Part A: Supervised Practice Completed Within the Educational Program**

I, the undersigned, verify that ____________________________ (print full name of AOCNP® candidate) has completed ____________________________ hours of supervised practice as an adult oncology nurse practitioner within the educational program. The supervised practice was completed between the dates of __________ - __________ (insert start and end dates of supervised practice).

Please check your role:
- Physician Preceptor
- Faculty member
- Nurse Practitioner Preceptor
- Other ______________________________________

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 AOCNP® candidate) has completed ____________________________ hours of supervised practice as an adult oncology nurse practitioner following graduation from the nurse practitioner program. The supervised practice was completed between __________ - __________ (insert start and end dates of supervised practice).

Please check your role:
- Supervisor
- Collaborating Physician
- Collaborating Advanced Practice Nurse
- Other ______________________________________

Name (print name) __________________________________________________________
Title _______________________________________________________________________
Name of Unit (if applicable) __________________________________________________
Name of Institution __________________________________________________________
Address _____________________________________________________________________
Daytime Telephone Number (with area code) ____________________________________
Signature ___________________________________________________________ Date __________

Return to ONCC. Fax to 412-859-6167, or mail to ONCC, 125 Enterprise Dr, Pittsburgh, PA 15275.