Certification Renewal Application - Option 3 (Test + ILNA)

Please read the information in the ONCC Test Registration 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 48 months (4 yrs.):   ________months
   - Total hours in oncology in the past 4 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 4 years (48 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.

<table>
<thead>
<tr>
<th>From: / /</th>
<th>To: / /</th>
<th>Title:</th>
<th>Employer:</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Number hours worked per week</th>
<th>% of time spent in oncology:</th>
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<tbody>
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### 11. Biographical Data (Optional)

- **Race**
  - American Indian/Alaskan Native
  - Asian
  - Black/African American
  - Caucasian/White
  - Mixed Race
  - Native Hawaiian/Other Pacific Islander
  - Other Race
  - Don’t 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 paying with my own funds.
  - My employer will be reimbursed by my employer upon successful certification.
  - I am an award winner

### 12. Demographic & Employment Information (Required)

- **Highest Nursing Degree**
- **Primary Position**
- **Primary Specialty**
- **Primary Patient Population**
- **Primary Work Setting**

- **Primary Functional Area**
- **Employment Status**
- **Number of hours worked per week**
- **% of time spent in oncology**

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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 (Full Fee)</th>
<th>Final Deadline (Full Fee)</th>
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<tbody>
<tr>
<td>ONS/APHON Member</td>
<td>September 15 $400</td>
<td>October 15 $500</td>
</tr>
<tr>
<td>Nonmember</td>
<td>$520</td>
<td>$620</td>
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</tbody>
</table>

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

Cardholder’s Name  Signature

Card Number  Expiration Date  CVV/CSC

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.

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) 859-6167