

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.

ONCC - Box 3445 • Dollar Bank
2700 Liberty Avenue, Pittsburgh, PA 15222
Toll Free: 877-769-ONCC • Phone: (412) 859-6104
Fax: (412) 859-6167 • www.oncc.org

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)

/ /

Birthdate

1. Which credential are you renewing?

OCN® CPHON® AOCNP CBCN® TCTCN™ _____ 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 Testing Accommodations due to a disability? No Yes (submit Testing 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 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

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

Sex
Female Male

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
- Patient Educator
- Pharmaceutical Representative
- Quality Improvement Nurse/Coordinator
- Staff Educator
- Staff Nurse
- Student
- Vice President/Chief Nursing Officer
- Other

Employment Status (select one)

- Full-time
- Part-time
- Retired
- Unemployed

Primary Functional Area (select one)

- Administration
- Consultation
- Education
- Patient Care
- Research
- Other

Primary Patient Population (select one)

- Adult
- Adult & Pediatric
- Pediatric
- N/A

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

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

Primary Specialty (select one)

- 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
- Transplantation & Cellular Therapy
- 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
- Infusion Services
- Neurology
- Occupational Health
- Prevention/Detection
- Primary Care
- Psychiatric/Mental Health
- Pulmonary
- Radiology
- Renal/Dialysis
- Solid Organ Transplant
- Urology
- Other

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

	Early Bird Deadline (\$100 savings included)	Final Deadline (Full Fee)
Renewal Option 3: Test + ILNA	September 15	October 15
<input type="radio"/> ONS/APHON Member	<input type="radio"/> \$ 400	<input type="radio"/> \$ 500
<input type="radio"/> Nonmember	<input type="radio"/> \$ 520	<input type="radio"/> \$ 620

- 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 form, I confirm that I have read, understand, and accept the conditions set forth in the Certification Renewal Manual, the ONCC Certification Test Registration Manual, and on the ONCC website concerning certification renewal, the administration of the examination, the reporting of examination scores, and certification policies, including confidentiality of ONCC examinations. I understand that an incomplete application that remains inactive for a period of 60 days will be purged from the ONCC certification application database. I confirm that I have read, understand, and agree to abide by the ONCC Code of Ethics Policy set forth on the ONCC website. I confirm that my RN license (including APRN license) is current, active, and unencumbered, and 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
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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