Certification Renewal Application - Option 3 (Test + ILNA)

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

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.

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® ❍ 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

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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 age range?

- ☐ 20-24 years
- ☐ 25-29 years
- ☐ 30-34 years
- ☐ 35-39 years
- ☐ 40-44 years
- ☐ 45-49 years
- ☐ 50-54 years
- ☐ 55-59 years
- ☐ 60-64 years
- ☐ 65-69 years
- ☐ Over 69 years

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

12. Demographic & Employment Information *(REQUIRED)*

Highest Nursing Degree (select one)

- ☐ Associate
- ☐ Bachelor's
- ☐ Diploma
- ☐ DNP
- ☐ Master's
- ☐ PhD/DNSc
- ☐ 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

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 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

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

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

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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
ONS/APHON Member	❍ $ 400	❍ $ 500
Nonmember	❍ $ 520	❍ $ 620

❍ 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.

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