

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 _____
(please specify role)

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 Advanced Practice Nurse
 Collaborating Physician Other _____
(please specify role)

Name (print name) _____
Title _____
Name of Unit (if applicable) _____
Name of Institution _____
Address _____
Daytime Telephone Number (with area code) _____
Signature _____ Date _____