ADVANCED CERTIFIED HOSPICE AND PALLIATIVE NURSE (ACHPN)
CANDIDATE PRACTICE HOURS VERIFICATION FORM

APPLICANT INFORMATION

Last Name _____ First Name _____ MI _____

Please note the following:

- If applying or reapplying for the initial ACHPN exam this form must be submitted for verification of a minimum **of 500 hours in the most recent 12 months or 1000 hours in the most recent 24 months** of supervised advanced practice palliative nursing.
- Individuals providing verification of supervised practice may be contacted during audit.
- You must provide multiple forms if verification is needed from more than one individual.
- Returned forms must be re-signed by the collaborating individual.
- Returned forms or incomplete applications may result in a delay of approval to test. Applicants will not be moved to the next testing window due to returned forms.

By signing below, I verify I have read, understand, and will comply with the information provided in this application.

Applicant Signature _____ Date _____

PART A: SUPERVISED PALLIATIVE CARE PRACTICE HOURS <u>WITHIN</u> AN ADVANCED HOSPICE AND/OR PRACTICE PALLIATIVE NURSING EDUCATION PROGRAM

Use this section to certify that the applicant has **<u>completed supervised clinical practice in advanced practice hospice and/or palliative care nursing within an education program.</u>**

☐ I, the undersigned verify the applicant **completed a minimum of <u>500 practice hours in the most recent 12 months</u>**.
☐ I, the undersigned verify the applicant **completed a minimum of <u>1000 practice hours</u> in <u>the most recent 24 months.</u>**

Select which program the applicant used to complete the practice hours above.
☐ Nursing Master's Program ☐ Nursing Post-Master's Program ☐ Doctor of Nursing Practice

Please indicate your role:
☐ Physician Preceptor ☐ Clinical Nurse Specialist Preceptor ☐ Nurse Practitioner Preceptor ☐ Faculty Member
☐ Other _____

PART B: OBSERVED HOSPICE AND/OR PALLIATIVE CARE PRACTICE HOURS AFTER GRADUATION FROM AN ADVANCED PRACTICE NURSING EDUCATION PROGRAM IN THE MOST RECENT 12 OR 24 MONTHS

Use this section to certify that the applicant has **<u>completed clinical practice in advanced practice hospice and/or palliative care nursing.</u>**

☐ I, the undersigned verify the applicant **completed a minimum of <u>500 practice hours</u> in <u>the most recent 12 months</u>**.
☐ I, the undersigned verify the applicant **completed a minimum of <u>1000 practice hours</u> in <u>the most recent 24 months.</u>**

Select the applicant's role in which you have observed and/or supervised them to complete the practice hours above.
☐ Clinical Nurse Specialist (CNS) ☐ Nurse Practitioner (NP)

Please indicate your role:
☐ Supervisor ☐ Collaborating Advanced Practice Nurse ☐ Collaborating Physician ☐ Collaborating Clinical Nurse Specialist
☐ Other _____

REQUIRED for Part A and Part B (to be completed by individual verifying practice hours)

Name (print name) _____ Title and Credentials _____

Address _____ Daytime Phone Number (with area code) _____

Email Address _____

Name of Facility or Organization (where supervised practice took place) _____

Clinical Setting (Clinic, Inpatient Unit, etc.) _____

Verifiers Signature _____ Date _____

Revised September 2023

ADVANCED CERTIFIED HOSPICE AND PALLIATIVE NURSE (ACHPN) CANDIDATE CHECKLIST

APPLICANT INFORMATION

Last Name **First Name** **MI**

Please note the following:

- **This form must be filled out in its entirety. Failure to do so will result in a delay in processing your application.**
- Copies of advanced practice education (transcripts) will be accepted.
- Required documents may be sent via email to AMPExamServices@psionline.com or mailed to
  - PSI c/o HPCC Certification Examination 18000 W. 105th St. Olathe, KS 66061-7543
- APRN licenses or verification documents must list an expiration date and the level of certification.

By signing below, I verify I have read, understand, and will comply with the information provided in this application.

Applicant's Signature **Date**

ADVANCED PRACTICE NURSING LICENSE

To be eligible to sit for the ACHPN exam, you must hold a current, unrestricted active APRN license or APRN certification in the United States, its territories or the equivalent in Canada. A copy of your APRN license must be submitted and is required as part of the application process.

Advanced Practice Credential (NP, CNS, etc.): _____

State(s) you are licensed to practice in: _____

Advanced Practice License Number: _____

ADVANCED PRACTICE DEGREE

To be eligible to sit for the ACHPN exam you must have proof of completion of an accredited graduate, postgraduate, or doctoral Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) educational program from a U.S. school or Canadian province NP or CNS educational programs approved by the Canadian Council of Registered Nurse Regulators (CCRNR).

Advanced Practice Degree Awarded: _____

Name of the College or University that awarded the above degree: _____

Year Degree Awarded: _____

ADVANCED PRACTICE EDUCATION

A copy of your academic record/transcript showing the graduate degree and date conferred is required. The transcript must demonstrate the key elements of APRN preparation, including completion of three separate comprehensive graduate-level courses in advanced pathophysiology, advanced health assessment, and advanced pharmacology, as well as a clinical practicum of at least 500 hours.

☐ **By checking this box, I certify that I completed 500 hours of clinical practicum as part of my APRN degree.**

Use the chart below to list where you completed the required courses', completion year, course number, and name.

- If your educational institution did not offer the course(s) below but was incorporated across the curriculum, please note this in the "Other" column.

Required Course	School	Year	Course #	Course Name	Other
Advanced Pathophysiology					
Advanced Health Assessment					
Advanced Pharmacology					