ADVANCED CERTIFIED HOSPICE AND PALLIATIVE NURSE (ACHPN) CANDIDATE PRACTICE HOURS VERIFICATION (PHV) 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 WITHIN AN ADVANCED HOSPICE AND/OR PRACTICE PALLIATIVE NURSING EDUCATION PROGRAM

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

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

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 **completed clinical practice in advanced practice hospice and/or palliative care nursing.**

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

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