CCRN Exam - Direct Care Eligibility Pathway
Audit Checklist

AACN #:	**Audit Due Date:**
Last Name:	**Exam Application Date:**
First Name:	**Email Address:**

Section 1:

Primary Position: _____ Number of Years in Critical Care: _____

Primary Area Employed: _____

Section 2:

The section must be completed by your verifier, who must be a **clinical supervisor or a professional colleague (RN or physician),** confirming that you have completed one of the two clinical hour options listed. **You cannot verify this information yourself.**

- Eligible hours are those spent in direct care of the patient population (adult, pediatric or neonatal) for your exam type, with the majority of the hours for eligibility (total and in the year prior to application) focused on *critically* ill patients.
- Nurses serving as manager, educator, APRN or preceptor may apply their hours spent supervising nursing students or nurses at the bedside. Nurses in these roles must be actively involved in direct care.
- Clinical practice hours for exam eligibility must take place in a U.S.-based or Canada-based facility or a facility with Magnet® designation or Joint Commission International accreditation.

Verification of Practice Hours

I, _____ , verify that _____
*(printed name of **verifier**)* *(printed name of **certificant**)*

has fulfilled the clinical hour requirements of direct care of the following acutely/critically ill patient populatoin:

Check ONE box only

► ☐ **Adult** ☐ **Pediatric** ☐ **Neonatal**

Hours completed were in alignment with the following exam eliibility option:

Check ONE box only

► ☐ **1,750** hours within the **2-year** period prior to application, with **875** of these hours completed in the 12 months preceding the *Exam Application Date* listed above.

☐ **2,000** hours over a **5-year** period, with **144** of these hours completed in the 12 months preceding the *Exam Application Date* listed above.

The majority of the total practice hours and those within the year prior to application for CCRN exam eligibility were focused on ***critically*** ill patients.

All fields MUST be completed

► _____ *Title*

_____ *Hospital Name*

_____ *Printed Name*

_____ *Hospital City / State / ZIP*

_____ *Signature*

_____ *Business Email*

_____ *Date*

_____ *Daytime Phone*

Please check this form for missing information and return it with a copy of your unencumbered RN or APRN license to brit.nicholson@aacn.org.

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Approved		Reviewer	