



E. What specific projects or educational activities have you been involved with or provided to nursing staff, the organization and/or patients to improve patient outcomes *as it relates to the care delivered to critically ill patients?*

The checked box and my signature below confirm that:

- I do not *exclusively or primarily* provide direct bedside patient care in my practice, *and*
  - I completed 1,040 practice hours *during the 2-year period noted above* with 260 of these hours *completed in the 12 months prior to the date noted above*, during which I positively influenced the care delivered to the following **acutely/critically ill patient population**:
    - Adult**    **Pediatric**    **Neonatal** (*check one box only*)
  - A majority of my practice hours for exam eligibility (total and in the year prior to application) were spent influencing patients, nurses and/or organizations to have a positive impact on the care delivered to *critically ill* patients.
- I confirm**

\_\_\_\_\_ *Certificant's Printed Name*

\_\_\_\_\_ *Certificant's Signature*

\_\_\_\_\_ *Date*

**Section 2 – VERIFIER**

Please review the above statement, complete and sign the below verification and **return to the certificant to include in their audit packet for AACN.**

To the best of my knowledge, I \_\_\_\_\_, confirm that the information above accurately reflects  
*(Printed Name of Verifier)*

the practice of this CCRN certificant. I understand that I may be contacted by AACN to validate the information provided.

\_\_\_\_\_ *Verifier's Title*

\_\_\_\_\_ *Verifier's Signature*

\_\_\_\_\_ *Date*

\_\_\_\_\_ *Hospital Name*

\_\_\_\_\_ *Hospital City/State*

\_\_\_\_\_ *Verifier's Business Phone*

\_\_\_\_\_ *Verifier's Business Email*

For office use only			
Received		Not Approved	
Approved		Reviewer	