CMC INITIAL EXAM 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 caring for acutely/critically ill *adult* patients, with a portion of the hours with *adult cardiac* 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 of cardiac patients.
- 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 requirement in direct care of acutely/critically ill **adult** patients in alignment with the following exam eligibility 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. Of these 1,750 hours, 875 were in the direct care of adult **cardiac** patients.

☐ **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. Of these 2,000 hours, 1,000 were in the direct care of adult **cardiac** patients.

All fields MUST be completed ►

_____ *Title*	_____ *Hospital Name*
_____ *Printed Name*	_____ *Hospital City / State / ZIP*
_____ *Signature*	_____ *Business Email*
_____ *Date*	_____ *Daytime Phone*

Please check your Initial Exam Audit Checklist for missing information and return it with a copy of your unencumbered RN/APRN license via email to brit.nicholson@aacn.org.

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Approved		Reviewer	