PCCN Exam - Knowledge Professional Eligibility Pathway
Audit Checklist

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

Section 1 - CERTIFICANT

This section must be completed by you and then given to your verifier, who must be a **supervisor or a professional colleague (RN or physician),** to complete, sign and return to you for submitting to AACN. **You cannot verify this information yourself.** Return this form with a copy of your unencumbered RN or APRN license.

Verification of Practice Hours – PCCN

A. Your role/title: _____

B. Primary Area Employed: _____

C. Give a brief description of how in your practice, *during the 2-year period prior to the date noted above*, you applied knowledge in a way that **influenced patients, nurses and/or organizations** to have a positive impact on the care delivered to **acutely ill adult patients**.

D. Provide several examples of how your practice resulted in positive outcomes for **acutely ill adult patients** (e.g., during the audit period, what changes has your practice resulted in?)

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 of* ***acutely ill adult 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 **acutely ill adult 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 PCCN 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	