**Nomination Form**

**NOMINEE INFORMATION**

**1. Name of organization being nominated:**

 Contact person:

 Address:

 City:       State:       Zip:

 Phone:      Email:

 Number of registered nurses employed by the organization: [ ]  Less than 25

 [ ]  25 or more

**2. Name(s) and city/state(s) of ONCC certified nurse(s) making the nomination:**  If nomination is by more than one nurse, please place an \* next to the name of the nurse to be contacted if further information is needed, along with contact information.

INSTRUCTIONS

Provide a detailed description of how this employer meets any or all of the following criteria. Please use specific examples.

**A. Sustained support of the OCN®-, CPON®-, CPHON®-, AOCN®-, AOCNP®-, AOCNS®-, CBCN®-, or BMTCN®-certified nurse role.**

 1. Describe how the organization indicates a preference/requirement for certified nurses in job descriptions or advertisements.

 2. Describe how the organization provides financial support for certification examinations, renewal, and/or examination preparation.

 3. Describe how the organization provides recognition of nurses who attain certification.