Application for Advanced Certification in HIV/AIDS Nursing (AACRN): Supervisor/Colleague Verification

Please print clearly.

Candidate Name: _____

Job Title: _____

Employer Name: _____

Employer Address: _____

City: _____State: _____ Postal Code: _____ Country: _____

Supervisor/Colleague Name: _____

Job Title: _____

Email Address: _____

Primary Phone: _____ Alternate Phone: _____

Give brief details of the above candidate's job role and experience:

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By my signature below, I verify that the above-named candidate for the Specialty Certification in Advanced HIV/AIDS Nursing Practice has a minimum of 2,000 hours of HIV/AIDS nursing experience within the five years prior to application.

Name: _____

Signature: _____

Date: _____