

# Approved Provider Eligibility Verification

## Intent to Apply/Renew

**Section 1: Demographic Data**

Organizations interested in applying for approval as an Approved Provider must complete the Eligibility Verification and meet all Eligibility Requirements. Verification forms received from organizations that do not meet Eligibility Requirements will be rejected without substantive review.

|  |  |  |
| --- | --- | --- |
| **Name of Organization/Applicant** |  | **Date Completed** |
| **Street Address** |  |  |
| **City State** | **Zip/Postal** | **Country** |

**Identify Organization Type**:

 Constituent Member Associations of ANA

 College or University

 Healthcare Facility

 Health - Related Organization

 Multidisciplinary Educational Group

 Professional Nursing Education Group

 Specialty Nursing Organization

 Other

Applicant is in compliance with all applicable Federal, State, and Local laws and regulations that apply to the delivery of NCPD.

 Yes No

E-mail Address

Primary Nurse Planner: Name and Credentials

Title/Position Telephone Number

##  Section 2: Nurse Planners

* All Nurse Planners are currently licensed registered nurses with baccalaureate degrees or higher in nursing.

 Yes No (If no, contact PSNA Accredited Approver Program Director at kstephens@psna.org)

* A Nurse Planner from the list below (or the primary nurse planner) is an active participant in the planning, implementing and evaluation process of ***each*** continuing education activity.

 Yes No (If no, contact PSNA Accredited Approver Program Director at kstephens@psna.org)

**List the names and credentials of all current nurse planners:**

|  |  |
| --- | --- |
| **Nurse Planner Name** | **Credentials** |
|  |  |
|  |  |
|  |  |
|  |  |

##  Section 3: Regional Target Market

During the past year, was at least 50% of your learning activities ***within*** the states of Region 3 – Pennsylvania, West Virginia, Virginia, Delaware and Maryland? (For region information, refer to [**http://www.hhs.gov/about/agencies/iea/regional-offices/index.html**)](http://www.hhs.gov/about/agencies/iea/regional-offices/index.html%29)

 Yes **If yes**, proceed to section 4

 No **If no**, the applicant organization is not eligible for Approved Provider status but may be eligible for Accredited Provider status. (For more information, refer to [**www.nursecredentialing.org/Accreditation**)](http://www.nursecredentialing.org/Accreditation%29)

##  Section 4:

**NEW Applicants only. Renewing Approved Provider Units, move to Section 5**

Answer the following questions and provide any additional required information.

* The applicant has been operational for a minimum of 6 months using the ANCC Accreditation Criteria.

 Yes **If yes**, proceed to the next item

 No **If no**, the applicant organization is **not** eligible for Approved Provider status

* The applicant has completed the process of assessment, planning, implementation, and evaluation for at least three separate educational activities provided at separate and distinct events, within the 6 months:
	+ with the direct involvement of a Nurse Planner,
	+ that adhered to the PSNA/ANCC accreditation criteria,
	+ that each learning activity was a minimum of 1 hour (60 minutes) in length (contact hours

may or may not have been offered); and

* + that were not provided jointly provided.

 Yes No

(ANCC, 2015, Primary Accreditation Manual: Provider)

##  Section 5: Eligibility

**The following section is intended to collect information about your organization’s corporate structure.**

## Is your organization one of the following? Check the box applicable:

* Ambulatory procedure centers
* Blood banks
* Diagnostic labs that do not sell proprietary products
* Electronic health record company
* Government or military agency
* Group medical practice
* Health law firms
* Health profession membership organization
* Hospital or healthcare delivery system
* Infusion center
* Insurance or managed care company
* Nursing home
* Pharmacy that does NOT manufacture proprietary compounds
* Publishing or education company
* Rehabilitation center
* School of medicine/nursing or health science university
* Software or game developer

**NOTE: 501c organizations are not *automatically* exempt.** The ANCC Accreditation Program requires 501c organizations to be screened for eligibility.

 **An "X" on this line identifies the applicant organization as exempt from ANCC’s definition of an ineligible company. Identify the applicant organization's exemption type from the bulleted list above and enter it here:**

\*Exempt organizations have completed this questionnaire and should proceed to Section 7: Attestation.

# Section 6 - Only complete this section if applicant organization is not exempt

The following questions must be answered, so PSNA Accredited Approver Unit can assess the applicant organization's eligibility.

* Does the applicant organization produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?

 Yes **If yes**, the organization is **not** eligible for Approved Provider status

 No **If no, complete the next bulleted question.**

* Is the applicant organization owned or controlled by a organization that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

 Yes **If yes, contact PSNA to review eligibility @apply@psna.org**

 No **If no,** you have completed this questionnaire and should proceed to Section 7.

# Section 7: Statement of Understanding

I attest, by my signature below, that I am duly authorized by (Insert name of organization) to submit this application as an approved provider offered by the American Nurses Credentialing Center (ANCC) through PSNA Accredited Approver and to make the statements herein. On behalf of the organization, I have read the approved provider eligibility requirements and criteria. I understand that the organization is subject to all eligibility requirements and criteria as an approved provider. I understand that becoming an approved provider depends on successfully meeting eligibility requirements and criteria and maintaining approved provider standing is dependent upon continued compliance.

On behalf of the organization, I expressly acknowledge and agree that information accumulated through the approval process may be used for statistical, research, and evaluation purposes and that anonymous and aggregate data may be released to third parties. Otherwise, all information will be kept confidential and shall not be used for any other purposes without the organization’s permission.

On behalf of the organization, I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature on behalf of the organization, that we will comply with all eligibility requirements and approval criteria throughout the entire approval period, including all reapplication periods for maintaining approval, and that we will notify PSNA Accredited Approver Unit promptly if, for any reason while this application is pending or during any approval period, the organization does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for approved provider status shall be sufficient cause for PSNA Accredited Approver Unit to deny, suspend or terminate the organization’s approved provider status and to take other appropriate action against the organization.

*(Applications received without a signature incur a delay in processing which will cause a delay in the review of the approval application.)*

An “X” in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

**Electronic Signature (Required) Date**

**Completed By: Name and Title**

**(Primary Nurse Planner is held accountable for all information provided)**

**Thank you for applying with PSNA.**

**Submit this completed Applicant Eligibility/Intent to Apply for Approved Provider Unit status form to**

apply@psna.org