Approver Accreditation Application/ Demographic Information Form

ANCC
AMERICAN NURSES CREDENTIALING CENTER
ACCREDITATION

Section 1: Demographic Information

Organizations interested in submitting an application for accreditation or reapplying to maintain accreditation as an Approver must complete the *Approver Accreditation Application/Demographic Information Form*. Organizations must meet all Eligibility Requirements and submit all forms according to the accreditation timelines. Forms received from organizations that do not meet the Eligibility Requirements will be rejected without substantive review. Applicant organizations must be adhering to the most current ANCC Accreditation Manual, available at the date of application, and answer the following questions:

To view timelines, click the paperclip icon:

Name of Applicant (Name on plaque, website, and accreditation statement)

Web Address

Street Address (P.O. Boxes not accepted)

City State Zip/Postal Country

If applicant is part of a larger organization, provide name of organization

Identify Organization Type: Select One

Requested Review Cycle: Select One

Section 2 • Please fill in all contacts.

1

Nurse Peer Review Leader: Name and Credentials (e.g. Mary Smith, MSN, RN)

Telephone Number Fax Number Email Address

2

Billing Contact if different from above: Name and Credentials (e.g. Mary Smith)

Telephone Number Fax Number Email Address

3

Additional Point of Contact: Name and Credentials (e.g. Mary Smith, MSN, RN)

Title/Position (e.g. Administrator)

Telephone Number Fax Number Email Address

Would you like ANCC's Directory of Accredited Organizations to include a hyperlink to your website? ☐ Yes ☐ No

Section 2: Eligibility Verification

Nurse Peer Review Leader's Name, Credentials and Title

Nurse Peer Review Leader is licensed registered nurse with a Master's degree or higher and either a baccalaureate or graduate degree in nursing? ☐ Yes ☐ No

Name as it appears on RN License:

RN License Number: State of Issue:

The Nurse Peer Reviewer Leader has authority within the organization to assure adherence to the ANCC Accreditation Program Criteria in the approval of each continuing nursing education activity and/or approved provider applicant? ☐ Yes ☐ No

The Nurse Peer Reviewer is an active participant in the evaluation process of **each** continuing nursing education activity and/or approved provider applicant (as applicable)? ☐ Yes ☐ No

Please list each Nurse Peer Reviewer's name (as it appears on his/her RN license), credentials, and state of licensure. (Note: Applicants outside the U.S., please contact the Accreditation Program Office at Accreditation@ana.org)

Nurse Peer Reviewer Leader	Nurse Peer Review Leader Credentials	Education Level	State of Licensure
		☐ BSN ☐ MSN ☐ Other: _____	
Nurse Peer Reviewers	**Nurse Peer Reviewer Credentials**	**Education Level**	**State of Licensure**
		☐ BSN ☐ MSN ☐ Other: _____	
		☐ BSN ☐ MSN ☐ Other: _____	
		☐ BSN ☐ MSN ☐ Other: _____	
		☐ BSN ☐ MSN ☐ Other: _____	
		☐ BSN ☐ MSN ☐ Other: _____	
		☐ BSN ☐ MSN ☐ Other: _____	
		☐ BSN ☐ MSN ☐ Other: _____	

To list additional Nurse Peer Reviewers, click here:

Has the applicant organization ever been denied accreditation, or had accreditation suspended or revoked? ☐ Yes ☐ No

The applicant organization has the infrastructure in place to operate as an Accredited Approver. ☐ Yes ☐ No

Applicant organization/unit is in compliance with all applicable Federal, State, and Local laws and regulations that apply to the approval of CNE activities or organizations. ☐ Yes ☐ No

Applicant organization has completed and attached, for the prior 12 months, both the:

Accredited Approver Summary of Approved Providers Continuing Educational Activities ☐ Yes ☐ No ☐ N/A

Accredited Approver Summary of Approved Individual Educational Activities ☐ Yes ☐ No

(**Note:** New Approver Applicants do not complete these two summaries at this time, but must have the infrastructure in place to function as an Accredited Approver Unit)

Section 3 • Statement of Understanding

I attest, by my signature below, that I am duly authorized by _____ (Insert name of organization) to submit this application for accreditation offered by the American Nurses Credentialing Center (ANCC) and to make the statements herein. On behalf of _____ (Insert name of organization), I have read the accreditation eligibility requirements and criteria. I understand that _____ (Insert name of organization) is subject to all eligibility requirements and criteria for accreditation as described in the current Accreditation Manual and any updates thereto. I understand that accreditation depends on successfully meeting eligibility requirements and accreditation criteria and that continued accreditation is dependent upon continued compliance. If accredited, _____ (Insert name of organization)'s name will be included in the official listing of ANCC accredited organizations.

On behalf of _____ (Insert name of organization), by my signature below, I authorize ANCC staff and the Commission on Accreditation to make whatever inquiries and investigations that they, in their sole discretion, deem necessary to obtain or verify information submitted with or necessary for review of this application.

On behalf of _____ (Insert name of organization), I expressly acknowledge and agree that information accumulated by ANCC through the accreditation process may be used for statistical, research, and evaluation purposes and that ANCC may enter into agreements to release anonymous and aggregate data to third parties. Otherwise, subject to the mailing list authorization, all information will be kept confidential and shall not be used for any other purposes without _____ (Insert name of organization)'s permission.

On behalf of _____ (Insert name of 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 _____ (Insert name of organization), that _____ (Insert name of organization) will comply with all eligibility requirements and accreditation criteria throughout the entire accreditation period, including all reapplication periods for maintaining accreditation, and that _____ (Insert name of organization) will notify ANCC promptly if, for any reason while this application is pending or during any accreditation period, _____ (Insert name of organization) does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for accreditation shall be sufficient cause for ANCC to deny, suspend or terminate _____ (Insert name of organization)'s accreditation and to take other appropriate action against _____ (Insert name of organization).

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

An "X" in the box below serves as the electronic signature of the individual completing this Accreditation Application Form and attests to the accuracy of the information contained.

☐ **Electronic Signature Required** **Date** _____ (MM/DD/YYYY)

_____

Completed By: Name and Title

Please complete and electronically return the following: 1) Approver Accreditation Application; 2) Accredited Approver Summary of Approved Provider Continuing Educational Activities (if applicable); and 3) Accredited Approver Summary of Approved Individual Educational Activities to: **Accreditation@ana.org.**

All forms are available on the ANCC website: **www.nursecredentialing.org/Accreditation**

****Organizations will be invoiced by ANCC and fee must be paid in full prior to the Accreditation Decision.**