ANCC
AMERICAN NURSES CREDENTIALING CENTER
ACCREDITATION

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Silver Spring, MD 20910

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nursecredentialing.org

Practice Transition Accreditation Program™ Application Form

Program Demographics

Official program name (this will be used on certificate, plaque, and directory if accredited)

Name of organization or practice setting(s)

Address

City State Zip Country

Do you place residents/fellows at multiple sites (e.g. more than one hospital, hospital and clinics, etc.)? If yes, you will apply as a "system-wide program." Please complete page 4, and see chapter 4 of the PTAP Manual. ◯ Yes ◯ No

Is this a vendor-based program? ◯ Yes ◯ No Name of vendor (if applicable): _____

Attach an executive summary of the program, including description of the organization or practice setting(s), program length, scope of the program, and number of residents/fellows accepted annually.

Practice Setting:

Population served (e.g. acute care, community-based, critical access)

Clinical areas seeking program accreditation (i.e. list the units/practice areas where residents/fellows are placed, such as medical-surgical, critical care, pediatrics, oncology, etc.)

Number of beds: _____

Type of program (see the PTAP Application Manual for Program Definitions): Select One:

Length of program: _____

Typical cohort size: _____

How many residents/fellows have participated in the program in the last 12 months (including graduates and current participants)? N = _____

NOTE: These participants will be asked to complete a survey regarding their perceptions of the program. At least 51% of this N must respond to the survey in order for the program to move forward in the accreditation process, regardless of their current status in the organization.

If successful, would you like a link to your website included in the ANCC directory of accredited practice transition programs?

◯ Yes ◯ No

Web address: _____

Year the program was established: _____

List credentials currently held by the organization (e.g., Centers of Excellence, Magnet®-recognized, state awards, Malcolm Baldrige National Quality Award, Top 100 Hospitals, etc.):

Program Director:

Name and credentials

Email Phone

Billing contact:

Name and credentials

Email Phone

Billing address if different from above:

Address

City State Zip Country

Additional contact person:

Name and credentials

Email Phone

Program Eligibility

The RN Residency/RN or APRN Fellowship Program Director holds a current valid license as an RN or APRN, a graduate degree or higher with either the baccalaureate or graduate degree in nursing, and education or experience in adult learning: ◯ Yes ◯ No

For applicants outside the U.S.: To validate international credentials, applicants must present verification from CGFNS International (http://www.cgfns.org/) of the Program Director's credentials. ANCC will not accept documentation from other credential evaluating organizations.

Program Director's name as it appears on RN license

License Number State of Issue

The Program Director has authority within the organization to ensure compliance with ANCC Practice Transition Accreditation Program criteria: ◯ Yes ◯ No

At least one cohort has graduated from the residency/fellowship program: ◯ Yes ◯ No

Applicant is in compliance with all applicable local, state, federal, and international laws and regulations that affect the applicant's ability to meet the ANCC Practice Transition Accreditation Program criteria? ◯ Yes ◯ No

Was program accreditation ever denied, suspended, or revoked by ANCC or any other organization? ◯ Yes ◯ No

If yes, describe:

Describe the eligibility criteria for your residents/fellows:

System-Wide (Multi-Site) Programs

If the program is implemented across a system or multiple practice sites, fill out this section.

List Site Clinical Coordinators:

Name (as it appears on RN license)	Credentials	Site	License Number	State of Issue

Attach an additional page if necessary.

Attach organizational chart(s). Organizational charts should show the entire system and should indicate the Program Director and Site Clinical Coordinators.

Attach an executive summary describing how the program is consistently operationalized throughout the system.

List Participating Sites:

List Non-Participating Sites:

Attestation

Insert your organization's name below, sign, and date electronically. Forms received without a signature incur a delay in processing which will cause a delay in the review of the accreditation application.

I attest, by my signature below, that I am duly authorized by: (insert name of Applicant Organization below)

_____

(hereinafter referred to as Applicant Organization) to submit this application for program accreditation offered by the American Nurses Credentialing Center (ANCC) and to make the statements herein. On behalf of Applicant Organization, I have read the Practice Transition Accreditation Program (PTAP) eligibility requirements and criteria. I understand that Applicant Organization is subject to all eligibility requirements and criteria for accreditation as described in the current Practice Transition Accreditation Program Application Manual and any updates thereto. I understand that program accreditation depends on successfully meeting eligibility requirements and accreditation criteria and that continued accreditation is dependent upon continued compliance. If accredited, the name of Applicant Organization Residency/Fellowship program will be included in the official listing of ANCC accredited programs with permission.

On behalf of Applicant 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, subject to applicable policies, laws, or regulations.

On behalf of Applicant 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 Applicant Organization's permission.

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

Checking the box below serves as the electronic signature of the individual completing this Application Form and attests to the accuracy of the information contained.

☐ Electronic Signature Required Date: _____

Completed By:

_____
Name

_____
Title

Please complete and email to practicetransition@ana.org.

NOTE: Your program will receive an invoice upon approval of this application. The application fee must be paid in full prior to the Accreditation decision.